CITATION: *Inquest into the death of Barbara Iris Francis (nee Cox)* [2020] NTLC 021

TITLE OF COURT:	Coroners Court
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FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Death of resident in aged care, dementia unit, understaffing, hip protectors, external/agency staff, Delay in ambulance attendance**

REPRESENTATION:

Counsel Assisting:	Jodi Truman
Counsel for Southern Cross Care Instructed by O'Loughlins Lawyers:	Stephen White
Counsel for St John Ambulance Instructed by Nicole Dunn Lawyers:	Greg Phelps

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

No. D0174/2018

In the matter of an Inquest into the death of

BARBARA IRIS FRANCIS (NEE COX)
ON 18 SEPTEMBER 2018
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Elisabeth Armitage

Introduction

1. Barbara Iris Francis (nee Cox) ("Mrs Francis") was born 16 April 1940 in East Melbourne to Phyliss and Methwy Cox. Mrs Francis had four siblings. Three (3) brothers are all still living and a sister who passed away in 2016.

2. On 1 January 1964 Mrs Francis married Kim Francis, an accountant. They had six children; Andrew, Timothy, Melissa, Natalie, Jeremy and Rebecca. The growing family lived in Nauru and Canberra before moving to Darwin in 1971. The family home was destroyed during Cyclone Tracy in 1974, but the couple rebuilt. Mrs Francis held a lifelong Catholic faith. She worked for a number of years at St Johns College and had an excellent relationship with the boarders. She loved to play tennis and won a number of amateur championships. In 1996 her husband died of cancer, aged 57.

3. In late 2012, when it was apparent that she was suffering memory loss and was repeating herself, Mrs Francis saw a geriatrician and was diagnosed with dementia. In spite of her diagnosis and deteriorating health, Mrs Francis remained in the family home until 2017 under the care of her daughter, Rebecca Kilpatrick.

4. By late 2016 Mrs Francis's health had declined to the point that it became too difficult to continue to manage her complex care needs at home. In February 2017 Mrs Francis entered residential care at Pearl Supported Care ("Pearl").

5. Mrs Francis was a resident at Pearl when she fell and broke her hip on 4 September 2018. Although Mrs Francis survived partial hip replacement surgery, she never recovered from the experience and she died in palliative care on 18 September 2018. Mrs Francis's family believed something had gone terribly wrong at Pearl the day Mrs Francis fell and they believed the fall was a catalyst for her death. An inquest was conducted in order to consider and determine the circumstances surrounding Mrs Francis's death.

6. Mrs Francis was dearly loved by her family and is greatly missed by them.

Pearl Supported Care

7. Pearl opened at 11 Waratah Crescent, Fannie Bay in 2011. It is one of several residential aged care properties operated by Southern Cross Care, a not-for-profit organisation established in South Australia in 1968. Pearl provides accommodation in 85 rooms over four wings: Mindil, Cullen, Lameroo and Dinah. Dinah (also known as the Memory Support Unit) is a secure wing for residents suffering from severe dementia-related illnesses. Dinah provides accommodation for 14 residents. Due to her diagnosis of dementia and related high care needs, Mrs Francis moved into a room in Dinah.

8. During her time at Pearl Mrs Francis began to experience falls. Incident reports from Pearl show that between 7 May 2017 and 4 September 2018, Mrs Francis fell on eleven occasions. Attempts were made to mitigate the risk of serious injury to Mrs Francis from her increasingly frequent falls. In August 2018 it was recommended that the family purchase hip protectors. Two sets were purchased and available for her use. Mrs Francis's

physiotherapist considered that Mrs Francis "should … wear hip protectors 24/7" because in her opinion and experience, hip protectors can prevent injuries.

9. As at 4 September 2018 there were a further eleven female residents and two male residents in Dinah. Mr A (whose name has been suppressed), aged 64, was the youngest resident in Dinah. He had been a resident at Pearl since March 2018 after being diagnosed with early onset frontotemporal dementia. I was informed that frontotemporal dementia is defined by a neurological decline which presents as a loss of empathy and behavioural dysregulation which can be exhibited as aggressive behaviour. Incident reports from Pearl reveal that Mr A had been involved in ten incidents of aggressive behaviour between 7 April and 4 September 2018. The incidents comprised mainly verbal threats towards staff but there were four incidents of physical violence. As is not uncommon in some older adults, Mr A also suffered from frequent urinary tract infections ("UTIs"). There is a recognised correlation between UTIs and behavioural disturbances in older adults. Behavioural management plans were documented for Mr A.

10. Mr A was entitled to receive one-on-one care for four hours each afternoon under the National Disability Insurance Scheme ("NDIS"). The one-on-one care was provided by an external Community Support Worker ("CSW") engaged by Australian Regional and Remote Community Services ("ARRCS").

11. There were aspects of Mr A's care at Pearl that his wife considered to be unsatisfactory. Complaints were raised internally with senior staff at Pearl and externally with the Aged Care Complaints Commissioner and the Aged Care Royal Commission.

Events of 4 September 2018

12. As at 4 September 2018 the staff roster for Dinah was:

12.1 One enrolled nurse from 7am-2pm and 4pm-8pm. On this day the afternoon shift was filled by a Registered Nurse, RN C;

12.2 Two personal care assistants ("PCAs") from 7am-3.06pm and 3pm-9pm. On this day both shifts were covered by the same PCAs, PCA T and PCA V;

12.3 One lifestyle staff member from 12.30pm-5.30pm, responsible for lifestyle programs. On this day there was no lifestyle member on duty and so Dinah was down one staff member during these rostered hours and no lifestyle activities such as group courtyard walks were offered to the residents;

12.4 One care coordinator (24/7), who was a registered nurse responsible for oversite of care in the whole facility (not situated in Dinah but available to Dinah as required). On this day the afternoon shift was filled by Care Coordinator B;

12.5 One care manager (day shift) responsible for whole of facility clinical care and governance (not situated in Dinah but available to Dinah as required). The care manager was away on sick leave and this position was not filled on the day;

12.6 One site manager (day shift) responsible for whole of facility program management (not situated in Dinah but available to Dinah as required). The site manager was Mrs Janet Marlborough.

13. PCA T commenced employment at Pearl in May 2018 and was qualified as a nurse in Nepal. PCA V commenced employment at Pearl in about February 2018 and was qualified as a nurse in the Philippines. Both PCAs T and V were rostered for and had completed their regular morning shift that day. However, when both PCAs rostered to work the afternoon shift called in

sick, PCAs T and V both worked a double shift to cover the afternoon shift. Double shifts were not common. It was the first time PCA V had been asked to do a double shift. Given that both PCAs normally only worked the morning shift I formed the distinct impression that both PCAs were not very familiar with the afternoon routine and staffing arrangements in Dinah.

14. In addition, on 4 September 2018 Mr A's usual NDIS carer also called in sick. CSW N accepted a last minute notification of the shift vacancy to cover Mr A's one-on-one afternoon care. CSW N had only worked at Pearl on one prior occasion. Although he had experience with persons suffering from dementia, CSW N had not previously met Mr A and had not previously worked in Dinah. When he accepted the shift, CSW N received a short "verbal handover" from one of the "schedulers" from ARRCS over the phone, which they have subsequently acknowledged was inadequate. He was told a little bit about Mr A and he was told to take Mr A out for a drive and that he liked playing cards. However he was not told that: Mr A was in the dementia unit; that he had a history of behavioural management issues and aggressive behaviour; and nor was he referred to his behaviour management plan or care plan. CSW N was not aware of Mr A's afternoon routine documented in a "duty list" which included a one hour drive, leaf blowing in the court yard on return from the drive, a clip board and check list and other specified activities.

15. CSW N commenced his shift just prior to 3.00pm. He only became aware that Mr A was in the dementia unit when he tried to enter Dinah and realised it was locked with an entrance code. CSW N had not been given the code by ARRCS and he was unable to find any Pearl staff to let him in. He rang ARRCS to obtain the code in order to gain access.

16. CSW N recalled that when he entered Dinah there were two Pearl staff sitting at the nurses' station. They must have been PCAs T and V as they were the only rostered staff in Dinah at that time. CSW N said that he

introduced himself and asked for Mr A. Mr A was pointed out to him in the lounge room. CSW N said that he was given no further information about Mr A or his afternoon routine. As PCAs T and V usually worked the morning shift it is likely that were not overly familiar with Mr A's afternoon routine. In addition, it is likely they did not realise that this was CSW N's first shift with Mr A. It seems no one took or had the time to properly communicate with each other.

17. CSW N approached Mr A and introduced himself. He noted that Mr A shook his hand and they chatted briefly. Mr A repeated himself several times and often used the phrase "Let's go" but CSW N considered this verbal repetition was "typical of dementia patients". CSW N's impression was that Mr A "seemed like a nice enough fellow" and "appeared quiet". CSW N recalled that between 3.00pm and 3.30pm he took Mr A for a drive, which was only half the length of Mr A's usual drive. He stated they made conversation and Mr A "was relaxed and seemed to be enjoying his outing".

18. While Mr A was out on his drive, PCAs T and V each recall undertaking normal resident care during the afternoon, which included pants changes. At about 3.15pm Mrs Francis needed to be cleaned and changed out of her clothing and they both took Mrs Francis into her room. They hurried to attend to Mrs Francis because while they were changing her all the other residents were left unsupervised.

19. Both PCAs recalled that Mrs Francis's hip protectors were soiled. Although she had two pairs of hip protectors, they were unable to find a clean pair in her room or in the laundry attached to Dinah and as a result, Mrs Francis was re-dressed without her hip protectors and returned to the lounge room.

20. CSW N recalled that after their drive, he and Mr A returned to Dinah, and they saw Mrs Francis standing just inside the door. He realised he knew Mrs Francis as they had attended the same church in the 1980s. CSW N sat with Mr A and Mrs Francis in the lounge room and talked to Mrs Francis about

the church and some people they both knew. It seems CSW N's conversation with another resident and sitting in the lounge area were not consistent with Mr A's regular afternoon routine.

21. RN C commenced her shift in Dinah at 4pm. RN C completed her nursing qualifications in 2017 and was employed as an agency nurse with the Altaira Nursing Agency. RN C's first shift at Pearl was on 1 August 2018. Her shifts at Pearl were ad hoc. 4 September 2018 was her second shift in Dinah. RN C was young, inexperienced and not overly familiar with the staff, routine or residents in Dinah. RN C saw CSW N but thought he was a visitor and did not appreciate he was employed to provide care to Mr A. RN C rang Care Coordinator B and requested a handover. While she waited for Care Coordinator B, RN C started reading the residents' seven day handover sheets at the nurses' station.

22. CSW N said that around 4.00pm he noticed that Mr A was "sun downing". Sun downing refers to a period of increased confusion and restlessness that dementia patients can experience during the afternoon or early evening. This period of agitation can be exacerbated by a change of routine and Mr A was out of his routine. CSW N noted that Mr A appeared "suspicious" of him talking to Mrs Francis and saw him pacing up and down the corridor. Mrs Francis was walking with Mr A and, according to CSW N, also showed signs of sun downing.

23. Some time between 4pm and 4.30pm both residents were encouraged to sit down and watch a movie. Mrs Francis and Mr A sat down near CSW N. CSW N recalled Mr A appearing "extremely agitated" and said that he was "staring directly into my eyes with a piercing stare". CSW N said he was "concerned…that things were going to escalate."

24. A few seconds later, CSW N saw Mr A "jump up" and start "swinging punches" towards him and Mrs Francis who was behind him. CSW N recalled Mr A swinging "at least three punches with both hands". Mrs

Francis screamed. One punch struck CSW N in the cheek bone which was painful. RN C called out to Mr A to stop.

25. Although RN C had limited recall of the incident when giving evidence, she confirmed that the statement she made to police was true. In her statement RN C recalled being in the nurses' station and seeing Mr A walk over to Mr N "make both his hands into fists and hit Paul (CSW N) in the face while he was still seated on the lounge".

26. CSW N gave evidence that after being struck, he left the lounge room to report the incident to his employer. He was not concerned about Mr A because he believed he had been isolated from the other residents by PCA V. CSW N spoke to his supervisor. He decided to stop work but was required to wait until another ARRCS worker arrived to replace him.

27. As he was on his tea break PCA V did not see the incident, but he was told of it and he immediately returned to Dinah and took Mr A back to his room and gave him some juice. He remained with him for five minutes or so. He then returned to the lounge room to assist PCA T with supervising the other residents and then started to prepare dinner.

28. While PCA V was in the kitchen preparing for dinner, PCA T was on her tea break, RN C was at the nurses' station and CSW N had not yet returned to Dinah. Mrs Francis was in the dining area when Mr A re-entered the lounge area. Mr A walked back and forth from the lounge area to the hallway.

29. CSW N said that he was only away for approximately five minutes speaking to his employer. When he re-entered Dinah he was surprised to see Mr A standing near Mrs Francis. He felt Mr A should have been isolated for a longer period of time to ensure he had calmed down. CSW N overheard part of a conversation between Mr A and Mrs Francis. Mr A was using his repetitive phrase "Let's go" and Mrs Francis responded, "I don't want to go,

I want to stay here". RN C heard a similar exchange and saw that Mr A seemed "sparked" by Mrs Francis's response.

30. CSW N was concerned that Mr A was still agitated and he started to walk quickly towards them. As he approached he saw Mr A "take up a boxing stance" and throw three punches at Mrs Francis. RN C also recalled that within seconds of the verbal exchange she saw Mr A hitting Mrs Francis "three times to the upper body area". PCA V said he saw one strike to the upper body. All of the witnesses gave evidence that it happened quickly.

31. All the witnesses saw Mrs Francis fall. Some recalled her falling on her bottom but CSW N was closest. He said that she fell "backwards onto her right hip" and that she was shouting "Please don't hurt me".

32. In her statement RN C said that she went immediately to Mrs Francis and recalled she was crying. She conducted an assessment and noted Mrs Francis had a right skin tear to the elbow which was bleeding. CSW N also provided assistance and recalled Mrs Francis smiling at him but also grimacing and that she was also "teary". PCA V put a pillow under Mrs Francis's head noting that she was in pain and couldn't stand up.

33. At about 4.50pm a call was made to Mrs Janet Marlborough advising her of the incident. Mrs Marlborough went straight to Dinah and saw Mrs Francis "expressing non-verbal signs of pain". Care Coordinator B was also notified, attended and undertook a full set of observations. Care Coordinator B recalled Mrs Francis was in a seated position on the floor with "a pillow behind her". She stated that Mrs Francis was "talking normally and laughing" but when she "started to check the movement of her legs, her facial expressions looked like she was in pain". Care Coordinator B stated it was clear "that something was wrong". She noted Mrs Francis's blood pressure was high which she considered indicative of pain. The physiotherapist also arrived at the scene and she described Mrs Francis as "clearly in pain but she couldn't tell us where exactly she was hurting" and

that it was “not abnormal for dementia patients to be unable to verbalise their pain locations”.

34. At 5.01pm Care Coordinator B called 000 for an ambulance. Care Coordinator B told the St Johns Ambulance (“SJA”) call taker that she suspected “a fracture of the lower leg” incurred after a punch and fall. Care Coordinator B reported that Mrs Francis was “conscious, breathing and in the care of a nurse”. She was reported to “be in pain” but “not reported to be exhibiting signs of shock”. Although the call taker did not record that Mrs Francis had been punched, which was very hard to hear on the 000 recording, the other information was recorded and based on this information the case was given a “Code 2 Alpha” response.

35. After her fall, Mrs Francis was not moved and stayed on the ground in the same position until the paramedics arrived at her side, which regrettably did not occur until 6.46pm. During this long delay RN C carried out observations on Mrs Francis at 4.30pm and again at 5.30pm. RN C recorded in her statement that “pretty much the whole time, Mrs Francis was crying and upset”. Other witnesses described her as laughing, grimacing and teary.

36. Shortly after calling the ambulance Care Coordinator B called Mrs Fitzpatrick and left a message informing her of her mother’s fall. Mrs Fitzpatrick returned the call and was distressed to hear her mother wailing in the background. Although counsel for Southern Cross Care attempted to place some doubt on this evidence, I reject the suggestion that Mrs Fitzpatrick heard another resident vocalising which she mistook for her mother. Mrs Fitzpatrick was very familiar with her mother’s voice and as a regular visitor to Dinah was also familiar with the frequent vocalisations of another female resident. I do not accept that she mistook or confused the two.

37. Care Coordinator B made a second call to 000 about 6.30pm and was told that the ambulance was on its way.

Arrival and involvement of St Johns Ambulance

38. The arrival of the ambulance was not without incident.

39. The SJA Communications Supervisor for the call centre that day was responsible for managing ambulance dispatch. Having reviewed the 000 call the Communications Supervisor maintained that a Code 2 classification was correct and the Code 2 classification would not have changed in any meaningful way if the punch had been recorded or if the fracture had been attributed to the hip as opposed to the lower leg.

40. The Communications Supervisor explained that a Code 2 is a Priority 2 response where an immediate threat to life is unlikely and lights and sirens are not utilised. For a Code 2, SJA aims for ambulance dispatch within fifteen minutes of receipt of the call.

41. Intensive Care Paramedic B ("SJA B") and Paramedic J ("SJA J") commenced night shift at 6.30pm. They were dispatched to Pearl at 6.31pm. They were not aware that the original 000 call had been made at 5.01pm.

42. Pearl is approximately 2kms from the Parap ambulance station and the ambulance arrived at 6.39pm. Both SJA officers stated that when they arrived there was no one to open the front door and no response to the intercom. As a result, a call was made back to SJA Communications requesting they call Pearl to enable access. The crew were then "buzzed in" but not met by Pearl staff. They found another resident in the foyer who they incorrectly thought was the patient, they checked again with SJA Communications on the name of the patient before eventually finding a woman sitting in an office who directed them to Dinah. The SJA officers arrived at Mrs Francis's side at 6.46pm.

43. They each observed that Mrs Francis was still on the floor, she was clinically stable but unable to bend her right knee and had no movement at the hip on the right hand side. She could rotate her right foot and had an

abrasion to her right elbow. She was hypertensive but otherwise unremarkable. The provisional diagnosis given by the paramedics, which proved to be correct, was a fracture to the neck of the right femur.

44. After their initial observations were made, SJA B went to fetch the stretcher from the ambulance but was critical of Pearl staff because he was not given the door code to exit and re-enter Dinah, nor was he accompanied by a member of staff. Pearl staff (who unbeknownst to the officers had been waiting for 1½ hours) were also critical of the officers for not bringing in the stretcher initially and because SJA B was rude. In addition the officers complained that the Pearl handover was inadequate and unprofessional, an opinion shared by RN C. While the handover might have been somewhat chaotic, the evidence established that Mrs Francis's records were copied and provided to the officers. The ambulance departed Pearl at 7.04pm and arrived at the Royal Darwin Hospital ("RDH") at 7.23pm with Mrs Francis being handed over to RDH staff at 7.42pm.

45. In his evidence SJA B complained that he had attended Pearl on multiple occasions and gaining entry there had always been difficult. In addition when SJA B learned of the 1½ hour delay until dispatch he was "dumbfounded as to why the job was held back and the day shift crew were not sent". He was concerned that this was "another occasion where SJA was trying to save money by not dispatching crews on overtime".

46. In response to the very legitimate concerns about the delay in dispatch and to the suggestion that the delay was a cost cutting measure, Counsel for SJA called evidence from Mr Craig Garraway, Manager of Emergency Communications Centre of Ambulance Services. Mr Garraway conducted a full review of the events involving SJA on 4 September 2018. Mr Garraway acknowledged that the time to dispatch an ambulance to Mrs Francis "was slower than satisfactory", which I consider an understatement, but explained the delay by reference to an analysis of the high number of calls received

during the period when the call concerning Mrs Francis was also received, the coding of those calls, and the vehicles available for dispatch. Mr Garraway's evidence was that although the delay in responding to the call for Mrs Francis was unacceptable, there were occasions when operational demand was greater than capacity and in those instances time targets could not be met and delays in dispatch occurred. Mr Garraway stated that unfortunately 4 September 2018 "was such a day".

47. In spite of those explanations, SJA maintained that the response time was unacceptable and conducted a review of their systems, policies and procedures in an effort to minimise the possibility of unacceptable delays in the future.

48. In light of Mr Garraway's evidence, counsel for SJA made the following submissions:

48.1 SJA has acknowledged that a delay of around 1½ hours in attending on Mrs Francis was unsatisfactory and apologized to the family.

48.2 SJA has provided a detailed analysis which explains that the delay was caused by the high demand for ambulance services in relation to the number of ambulances available.

48.3 On its own internal review of the matter, SJA identified some errors in communications and in procedures but these did not impact the manner in which Mrs Francis was attended by SJA.

48.4 Since September 2018, SJA has: implemented a "Surge Plan" to manage both anticipated and unexpected surges in work load; has rostered a Communication Duty Manager each day to provide an additional level of supervision in Communications; and now requires any dispatch delays longer than 30 minutes to be reported to and reviewed by the Operations Duty Manager.

48.5 The delay in the dispatching the ambulance to Pearl Nursing Home did not cause or contribute to Mrs Francis's death.

Events following admission to Royal Darwin Hospital

49. Evidence provided by RDH revealed that Mrs Francis was brought in by ambulance and was "unable to weight bear on her right leg". As a result she was admitted to the orthopaedic ward. It was noted that aside from the injury she was in an extremely vulnerable state of health suffering from a number of comorbidities, namely:

49.1 Ischaemic heart disease;

49.2 Severe coronary artery disease;

49.3 Congestive cardiac failure;

49.4 Atrial fibrillation;

49.5 Hypertension;

49.6 Chronic obstructive pulmonary disease;

49.7 Chronic urinary tract infection; and

49.8 Dementia.

50. Mrs Francis was diagnosed as having a "right sub-capital neck of femur fracture" and on 7 September 2018 she underwent surgery for a Hemiarthroplasty (a partial hip replacement). The records indicate that Mrs Francis survived the surgery but on 11 September 2018 she suffered from bradycardia (abnormally slow heart) and hypotension (low blood pressure) and "was not responding to treatment". Her condition was discussed with her family and she was referred to palliative care on 12 September 2018 for end of life care.

51. Mrs Barbara Francis passed away at 3.10pm on 18 September 2018.

Findings at autopsy

52. Dr John D. Rutherford performed the autopsy upon Mrs Francis on 20 September 2018. Dr Rutherford noted her past medical history of "chronic obstructive pulmonary disease, hypertension, atrial fibrillation and congestive heart failure as well as dementia".

53. Dr Rutherford gave evidence that Mrs Francis suffered from "multiple pathologies" and that as a result "there are several ways of expressing the cause of death". Dr Rutherford explained Mrs Francis's cause of death as follows:

> "(Mrs Francis's) general pattern of deterioration would suggest progressive failure of the cardiorespiratory system attributable to long-standing chronic obstructive pulmonary disease, ischaemic heart disease and hypertensive heart disease. Whilst the fall that she had in the nursing home may have been a contributing factor by disturbing the haemodynamic of a pre-existing precarious cardiorespiratory status, I note that there was an interval of several days when her post-operative recovery seem to be satisfactory.
>
> Given the foregoing, it is my view that death is best expressed as cardiorespiratory failure as a consequence of the combined effects of chronic obstructive airways disease, hypertensive heart disease and ischaemic heart disease. Osteoporotic fracture of the neck of the femur might reasonably be considered to be a precipitating/contributing factor given that, on balance of probability, she would not have died when she did were it not for the fall".

54. As discussed earlier, Mrs Francis was prone to falls and to mitigate the risk of injury the physiotherapist had recommended, and the family had provided her with, hip protectors. Counsel for Southern Cross Care conceded that Mrs

Francis “should have been wearing her hip protectors”. That she was not wearing her hip protectors when this incident took place was a matter of significant concern. Dr Rutherford was asked whether, if Mrs Francis had been wearing her hip protectors at the time of her fall, this might have prevented the fracture. Dr Rutherford initially provided the following opinion:

> “I make the presumption that the focus of your concern is the fractured neck of femur for which she was admitted to hospital and which might by some be regarded as a precipitating factor for the natural cardiorespiratory failure probably exacerbated by the inevitable haemodynamic disturbance associated with essential surgery.
>
> There were no marks on the body to suggest a direction of fall, point of impact or, indeed, any other significant trauma. I am unable, therefore, to distinguish a natural fall (due to unsteadiness) from a malicious act (such as a push). By the same token. I am unable to say from the pathological findings whether she fell onto her left hip, right hip, bottom or elsewhere.
>
> The impact site is somewhat immaterial in an osteoporotic fracture of this type which is due to mechanical strain being disproportionately focussed on a particular region; this force may be direct impact, but is often transmitted and/or remote as in twisting or bending as might occur in stumbling or impact elsewhere, with leverage on the hip region. It is not so uncommon to come across cases where the hip has fractured quite spontaneously from natural weakness and the fall has been secondary to the fracture. There is no pathological evidence in this case to support either view.

The weakness (thinning or rarefaction) of the bone in osteoporosis may be localised and, although it may be possible to semi-quantitate the degree of thinning, it is not within my field of expertise and is usually done by a radiologist with a special interest in the subject on in vivo radiographs.

As far as I am concerned, her essential cause of death was cardiorespiratory failure from underlying natural disease with the fracture (and essential surgery) as precipitating and/or contributing factors. Death from cardiorespiratory causes would not have been far away regardless of any trauma. The dementia has nothing to do with it in the sense that we encounter similar situations in people who do not have dementia"

55. However, during the course of the evidence it became clear that CSW N saw Mrs Francis fall onto her right hip. He recorded this description in notes he made shortly after the event occurred and again within a week of the fall when he was asked to provide further details. In addition, I note that the other injury Mrs Francis suffered, namely a skin abrasion to her right arm, was also on her right side. CSW N was consistent over time about Mrs Francis falling onto her right hip.

56. As a result of that evidence, Dr Rutherford provided the following further opinion:

"As I understand it, a witness has clearly stated that Mrs Francis fell directly and clearly onto her right hip (the one that was fractured and subsequently repaired by hemi-arthroplasty) raising the question "is it possible that wearing a hip protector could have prevented a fracture?"

"Whilst in giving evidence yesterday I indicated that a significant number of hip fractures occur as a result of torsion in the limb and

that sometimes osteoporotic fractures seem to occur spontaneously without anything much in the way of direct or indirect trauma, I also acknowledged that some occur because of direct trauma. It is important to observe here that my experience is with people who have died which may well be a different demographic from those who survive and therefore an orthopaedic surgeon who deals with those who survive may have a different perspective to my own; I have not done a full literature search (which would take some time) to address this potential difference.

"Thus, direct trauma cannot be excluded as a cause of the damage in the case of Mrs Francis and assumes more significance in the light of clear witness evidence. However, slightly against the hypothesis of direct impact trauma to the hip is the absence of bruising in either hip region at autopsy. If the decedent was on anticoagulants as suggested by Mr White (?), then the likelihood of residual bruising would be higher, and this might even persist for several weeks; in such cases it is often seen as greenish-yellow discolouration (as the red haemoglobin pigment is metabolised) that migrates slowly under gravity as the days and weeks progress such that it is often seen further down the thigh rather than over the hip (and may well be seen at autopsy). For what it is worth, no such bruising was seen in Mrs Francis.

Notwithstanding the foregoing, if the assumptions are made that (a) she fell onto her right hip, (b) the fracture was a consequence of that fall and (c) there was no torsional component to the injury, then it is possible that a hip protector may have attenuated the impact and resulted in the avoidance of a fracture.

On brief perusal of the literature (not comprising a thorough literature research), it does appear that hip protectors are of value in

protecting from fracture in the elderly. According to Google they vary in price (from about 10 AUD to >240 AUD) which means they probably also vary in quality. I cannot find dimensions, but they appear from the pictures to be foam rubber and between 1 and 2 cm thick. I am not privy to the type of hip protector that was available to Mrs Francis."

57. Dr Rutherford found that the cause of death was "cardiorespiratory failure from underlying natural disease with the fracture (and essential surgery) as precipitating and/or contributing factors". Even though Mrs Francis was precariously unwell, the fracture and subsequent surgery were precipitating factors in her death.

58. In light of CSW N's evidence and the opinions of Dr Rutherford and the physiotherapist the evidence pointed to it being more likely than not that had Mrs Francis been wearing her hip protectors she may have avoided the fracture to her hip and subsequent surgery.

The care and management of Mrs Francis at Pearl by Southern Cross Care

59. The evidence established that on this day Dinah was understaffed. Mrs Francis's family complained that this was not uncommon. When they visited Mrs Francis sometimes there was only one staff member in Dinah and sometimes none. It is apparent that management were well aware of the staffing concerns in Dinah. On 27 December 2017 Ms Marlborough issued an important directive to all staff concerning Dinah which included the following directions:

59.1 Please ensure at all times the residents are observed in the Dinah wing.

59.2 There must be three staff at all times during the day in the wing up until 8.30pm in the evening.

59.3 Only one staff member must be absent at any one time from the unit including the lifestyle person. This includes meal breaks.

59.4 The Care Manager or Residential Service Manager will attend a part of each lunchtime meal service.

59.5 This is not to be changed unless there is communication with me.

60. In spite of this directive, on 4 September 2018 between 2pm and 4pm there were only two staff on duty in Dinah. It follows that when PCAs T and V were changing Mrs Francis, there were no other staff supervising the remaining residents. The lifestyle member rostered between 12.30pm and 5.30pm was not at work. In her tendered statement Mrs Marlborough explained that "should the unit be short staffed due to exceptional circumstances (unable to replace sick for example) the care manager and or manager must be notified immediately and at all times. If necessary the Care Coordinator will work in the unit to ensure the safety of all residents". Even though those systems were purportedly in place, in her evidence Mrs Marlborough said "I found out after the fact that there was no lifestyle person there. Nobody had brought it to my attention. At that time we did have a worker who was prone to not arriving to duty and I am assuming it was one of those days". From that evidence I further conclude that neither the Care Manager nor the Residential Service Manager attended the lunch time meal (in accordance with the Directive), because if they had done so they would have been aware that the lifestyle member had failed to attend. Mrs Marlborough conceded that the Care Coordinator on duty that day did not step in and provide assistance in circumstances where that should have occurred; and further, that the absence of the lifestyle member contributed to the events of 4 September 2018. The failure of the lifestyle member to attend for work and for that absence to go unrectified was inadequately explained. While staffing rosters and directives existed, management failed

to ensure they were implemented. Mrs Francis's family said that those failings were not limited to 4 September 2018.

61. Although the two PCAs on duty were experienced care assistants and familiar with Dinah and its residents, the same cannot be said of other persons working in Dinah that day. RN C was relatively inexperienced. RN C became qualified in late 2017, and had only started as an agency nurse at Pearl on 1 August 2018 with irregular shifts. On 4 September 2018 RN C was working her second shift in Dinah and was clearly not sufficiently familiar with the residents or the processes and procedures of Dinah. For example, RN C did not have any "guidance or training" about the use of hip protectors which was an important aspect of Mrs Francis's care plan. Although RN C commenced work at 4pm it appears she was at a bit of a loss as to what to do while she waited for Care Coordinator B to attend and provide a handover. As discussed earlier the handover did not occur before the fall, and possibly not at all, as when Care Coordinator B did attend Dinah at about 4.45pm it seems she was entirely engaged with caring for Mrs Francis. As RN C had worked a number of shifts at Pearl, management ought to have identified that, in spite of the orientation conducted on 9 August 2018 and her qualifications, she was inexperienced, lacked confidence and required additional mentoring and training.

62. While management at Pearl appeared unconcerned by or oblivious to RN C's limitations, she herself was not so naive. In her statement she recalled that after her first shift at Pearl she phoned the Operations Manager at Altaira and requested "buddy shifts" so that "I could learn what I needed to do working at Pearl", however "buddy shifts" were not provided. Consistent with the lack of handover on 4 September 2018, in her statement RN C identified that "there was never any real consistency with handovers at the start of my shifts". RN C also identified that she had not been trained about external carers coming into Dinah, which likely contributed to her confusion as to the role of CSW N. In addition RN C said: the procedures in looking

after and caring for the patients were not clear, documentation was all over the place with some on computers and some on paper, and there was a lack of staff. RN C resigned shortly after this incident. In her evidence she said "if it wasn't this incident, I believe it would have been something else at Pearl".

63. CSW N was uninformed concerning the policies and procedures of Pearl, Dinah, the residents, and more importantly the specific needs of the one person he was responsible for, Mr A. He had received no induction or orientation to the site or his client. He was not given Mr A's care plan, behaviour management plan or duty list nor was he advised of Mr A's history of aggression. It was clearly not the responsibility of the two PCAs to provide orientation to CSW N during a busy shift.

64. While it is accepted that ARRCS bore some responsibility for back-filling the shift with a person who had not been oriented to Pearl or Mr A, ultimately the responsibility and the duty of care to Pearl residents rested with Southern Cross Care and Pearl. The policies and procedures of Pearl ought to have ensured that external agency workers coming onto the premises to deliver services to residents were qualified, orientated to the client and the site, and sufficiently experienced to undertake the role that they were there to be perform. Whatever policies and procedures that existed at that time, they were clearly inadequate or inadequately adhered to insofar as CSW N was concerned.

65. That CSW N was: able to enter Dinah without reporting to a staff member or signing in, engage with a resident, take the resident off premises; all without any Pearl staff confirming his role or recognising him, is alarming. Because he was not given appropriate orientation or information, CSW N was not aware of and did not follow Mr A's duty list. Mr A was out of routine and it is more likely than not that this contributed to Mr A's agitation and aggressive conduct that day. In her evidence, Mrs Marlborough accepted

that having a NDIS worker who was not familiar with the site or his client contributed to the events of 4 September 2018.

66. If Mr A had been following his afternoon routine, and if a lifestyle member had been present in Dinah, it is unlikely that the CSW, Mr A and Mrs Francis would have engaged in conversations that gave rise to Mr A feeling possible jealousies or frustrations. Further, it is unlikely that Mr A and Mrs Francis would have been permitted to pace the corridor and sun down together. In addition, had the lifestyle member been on duty (that is, one additional staff member available in Dinah at the time of the incident with CSW N) it is likely that Mr A would have been supervised and isolated from other residents for a longer period after the initial incident of aggression with CSW N. Had the staffing roster and important directive been complied with, and had the CSW been adequately orientated to the site and the client, the entire incident resulting in Mrs Francis's fall could have been avoided. In those circumstances it is likely that Mrs Francis would not have died when she did.

What has been done to rectify the issues that contributed to Mrs Francis's death?

67. Relying on Pearl's current "Guidelines for the overall day-to-day Management and Governance Dinah" ("the Dinah Guidelines"), it is apparent that since this incident staffing levels and composition have largely remained unchanged. Mrs Marlborough said that a third PCA was in the unit for one hour every lunchtime but this is not reflected in the current Guidelines. In her evidence PCA T said that since the incident with Mrs Francis the lifestyle person is now always there and she is aware she can ask for extra staff if it is needed. PCA V stopped working at Pearl in January 2019 but said that he had not noticed any changes before he left. Neither PCAs recalled an extra PCA assisting with the lunch hours.

68. While little has changed concerning staffing numbers, with at best one undocumented additional PCA to help out with lunch for one hour each day, Mrs Marlborough gave evidence that there were a number of changes made to the policies and procedures at Pearl in relation to the:

68.1 orientation and induction;

68.2 training;

68.3 experience; and

68.4 familiarity

of those who work in Dinah.

69. Some of the changes made or committed to which are relevant to the issues arising in this Inquest are as follows:

69.1 The Dinah Guideline now provides that agency staff are not to work in Dinah except if approved by a manager and as a last resort. Mrs Marlborough explained that staff rostered to Dinah will now be employees of Southern Cross Care and not sourced from outside agencies to ensure that staff are familiar with not only the policies and procedures of Pearl and Dinah, but even more importantly with the specific care needs of the residents in Dinah. In addition, I consider that the Dinah Guideline and roster should be further amended to reflect that an extra PCA (or equivalent) is to be present in Dinah for one hour during the Dinah lunch hour. Without this amendment it seems there remains a possibility that the staffing numbers will reduce to two staff only as there is a possibility of a rostering gap when no EN/RN is on duty and when the lifestyle member starts at 12.30pm or possibly 1pm, as was Mrs Marlborough's oral evidence.

69.2 A NDIS Guideline has been developed and implemented. NDIS staff must have attended a site orientation and signed an Orientation

Booklet before they are permitted to work with a resident. Agencies must not send workers to Pearl who have not been inducted and must notify the manager if the NDIS Worker is sick or running late. Mrs Marlborough explained that the orientation of all NDIS workers had to be prearranged with Pearl and was conducted over a four hour period. Agencies that provided NDIS workers were to notify Pearl of any new workers so that they could be inducted before they were allocated shifts at Pearl. NDIS workers are now also required to sign in and out of the facility and report to the RN on arrival. It was noted during Mrs Marlborough's evidence that while the policy refers to site orientation, it failed to make reference to client/resident orientation. Mrs Marlborough undertook to amend the Guideline to include a requirement for induction to the client/resident.

69.3 The NDIS Guideline further provides that after signing in on-site, all NDIS workers are now to be provided with an information folder which contains information relevant to the care needs of the resident (including a summary care plan) and a care bag and must advise the RN/EN of any outing before leaving the unit.

69.4 In her evidence Mrs Marlborough advised that there was a new handover process. The off-going care coordinator and the on-coming care coordinator visit every wing together to conduct a hand over with all persons going-off and coming-on shift. Mrs Marlborough said that the process takes about 30 minutes. This procedure is designed to ensure that the care coordinators are aware of any staffing or clinical issues across the facility.

69.5 A new staff guideline has been issued concerning the management of hip protectors. If a resident is identified as having a high risk of falls the family will be asked to provide three sets of hip protectors, one for wearing, one for laundering and one spare. Soiled hip protectors are

to be washed and returned on the same day. The guideline provides that: “It is mandatory for residents clinically assessed as requiring hip protectors to have these fitted daily 24/7, or as per the instruction on the resident’s care plan,” and; “It is the responsibility of the Nursing Staff to monitor compliance”.

69.6 Having heard of the various difficulties surrounding the 000 call and the ambulance officers access to the site, Mrs Marlborough committed to formalising a 000 policy which will include: that the call back number to be provided on any 000 calls is the mobile number of the Care Coordinator; and that follow up 000 calls are to made by the Care Coordinator no later than 30 minutes after the previous 000 call (or sooner if the situation warrants). It would also be prudent to address the handover procedure to ambulance officers to ensure that relevant information and documents are provided efficiently.

70. In closing submissions counsel for Southern Cross Care accepted the proposition that “The whole management of Mr A failed that afternoon. It failed for Mr A and it failed for Mrs Francis.” That the level of care provided by Pearl was lacking on 4 September 2018 was ultimately accepted by Mrs Marlborough when she reflected on the evidence that she had heard at the Inquest and said “the events over the last few days have clearly identified that we could have done better on the day…We have done a lot to overcome the gaps that we’ve had. It has been identified that there are still some things we can improve and we give the family the commitment that we will.”

71. At the start of the Inquest Mrs Fitzpatrick read a family statement which explained the family’s loss and grief concerning the manner in which their mother died and their added distress at the way the incident was handled by Pearl. Moving forward Mrs Fitzpatrick said: “As a family we hope from the Inquest of our amazing mother that Southern Cross Care will make Pearl the

nursing home that it should be. That our loved ones, our mothers, fathers, sisters, brothers, we entrust to your staff, are afforded the care they deserve. Most of the elderly that are in your care helped build this town – the least we can do is ensure that their final days are lived in a dignified and loving manner."

Formal Findings

72. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased was Barbara Iris Francis nee Cox born on 16 April 1940, in Melbourne, Victoria, Australia.

(ii) The time of death was 3.10pm on 18 September 2018 at Royal Darwin Hospital Hospice facility.

(iii) The cause of death was cardiorespiratory failure, ischaemic and hypertensive heart disease together with chronic obstructive pulmonary disease following an osteoporotic fracture of neck of femur which had been treated by hemiarthroplasty.

(iv) The particulars required to register the death:

1. The deceased was Barbara Iris Francis.

2. The deceased was of Caucasian descent.

3. The deceased was retired.

4. The death was reported to the coroner.

5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.

6. The deceased's mother was Phyllis May Cox (deceased) and her father was Methwy Stewart Francis Cox (deceased).

Recommendations

73. Given the changes made by St Johns Ambulance to address the issues identified by this Inquest, I make no further recommendations.

74. Given the changes made and commitments given by Mrs Marlborough on behalf of Southern Cross Care to address the care issues identified by this Inquest, I make no further recommendations.

Dated this 18th day of December 2020.

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JUDGE ELISABETH ARMITAGE
TERRITORY CORONER