



**STATE CORONER'S COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the death of Beryl Joyce WATSON
Hearing dates:	26 to 28 March 2014
Date of findings:	23 May 2014
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate Michael Barnes, State Coroner
Catchwords:	CORONIAL LAW – short stay aged care residents; caring for non commutative patients in aged care facilities
File number:	2012/140588
Representation:	<p>Ms Belinda Baker instructed by Ms Loren Collyer Counsel Assisting the Coroner.</p> <p>Mr William De Mars instructed by Mr James Herrington representing Mr Clive Watson.</p> <p>Mr Gary Gregg instructed by Ms Dannielle Stockeld representing MDA National Insurance.</p> <p>Ms Kim Burke instructed by Ms Amy Cook representing Dr Mark Smith.</p> <p>Mr Ben Clark instructed by Mr Edmund Waters representing Bupa Care Services.</p>

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The Coroners Act in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Beryl Watson.

Introduction

As a result of a number of serious illnesses, for the last 10 years of her life, Beryl Watson was severely disabled and required full time care. This was dutifully provided by her husband Clive in their home near Kempsey.

In November 2011, Mr Watson had to go to Sydney for a medical procedure. He arranged for his wife to stay at the BUPA Aged Care Facility in Kempsey for the three weeks he was going to be away.

Five days after Mr Watson collected his wife from the aged care facility, she was admitted to the Macksville General Hospital. Ten days later she died in hospital from aspiration pneumonia.

This inquest has made findings confirming the identity of the deceased woman, the date, place and cause her death. It has investigated aspects of the manner of Ms Watson's death, in particular, whether any sub-standard care provided to her while she was in the BUPA Aged Care Facility, caused, or contributed to her death.

The evidence

Social & medical history

Beryl was born in 1941. When she was 20 she married Clive Watson. They had been married for 50 years when Beryl died at age 70 in 2011. They have two children.

Commencing in 1986, there were concerns that Beryl might be developing dementia. These were investigated over the next few years. When the diagnosis was confirmed in 1994, Mr Watson retired and became his wife's full-time carer.

Her health continued to deteriorate. In 1996, she was diagnosed with Huntington's disease. From about that time onwards, she was unable to walk without assistance, and used a wheelchair. In about 2000, Ms Watson became incontinent of urine, and would frequently contract urinary tract infections. Her husband managed this with the use of large pads for her bedding at night and her chair during her day.

The Watsons developed a close therapeutic alliance with Beryl's GP, Dr Mark Smith, who practised at Nambucca Heads. They involved a dietician, a physiotherapist and a speech pathologist in the development of a care plan for Ms Watson. It involved his wife having the requisite amount of thickened fluid each day in carefully measured amounts, taken while she was sitting upright and her head supported and fed to her by spoon. It also involved Ms Watson sitting in an adjustable chair for most of the day, rather than lying down and her sleeping naked while lying on absorbent pads. This approach limited the likelihood of her choking while eating or secretions building up in her throat. It also limited the likelihood of urine scalding, a real risk for someone in her condition.

Mr Watson researched care strategies and willingly took advice. All of the evidence indicates he was very successful in limiting the avoidable symptoms of his wife's illnesses.

In 2006 and 2009, Ms Watson spent periods in two different respite centres as a result of her husband being unable to care for her for short periods. Those stays apparently proceeded without incident.

In November 2009, an Aged Care Assessment Team arranged for Mr Watson to receive seven hours of respite care per week for Beryl in their home. In Mr Watson's view, the respite care provided under that program by Community Care Options from Urunga was of a high standard and worked well for the couple.

In September 2011, Mr Watson became aware that he would need to go to Sydney for a medical procedure, which was booked for 14 November.

He arranged through the Commonwealth Respite and Carelink Centre for Beryl to have respite care during the time he anticipated being away: 10 November to 1 December. Ms Watson was booked into the BUPA Aged Care Facility in Cochrane Street, Kempsey.

Pre-admission consultations

On 26 October, Mr Watson went to the facility and met with the Manager, Sharon Fritsch. He inspected the premises and completed paperwork provided to him by Ms Fritsch. He outlined Ms Watson's requirements as described in her care plan. The evidence is not clear as to whether a copy of that plan was provided to Ms Fritsch on this occasion, although it is clear that a copy was given to BUPA staff when Ms Watson was admitted two weeks later.

Mr Watson and Ms Fritsch discussed the need to manage Beryl's urine incontinence and her feeding requirements. The care plan listed the medications Ms Watson was routinely prescribed. They included Rivotril, a proprietary name for clonazepam, a benzodiazepine drug having anti-convulsant and muscle relaxant sedatives that had been prescribed to Ms Watson for a number of years to assist the treatment of her chorea, the involuntary muscle movements caused by Huntington's Disease.

On 4 November, Beryl had an appointment with her GP for a check-up and to enable Dr Smith complete some more paperwork required by the BUPA Aged Care Facility. Dr Smith said she seemed her normal self on this occasion and that Mr Watson did not raise any concerns about her health. He printed a list of Ms Watson's prescribed medications for Mr Watson to give to the BUPA aged care facility. Because the use of Rivotril had been discontinued earlier in the year and then re-commenced, it was only noted in her paper chart and not included on the digitally stored and created medication list that was given to Mr Watson to provide to the BUPA facility when Ms Watson was admitted a few days later. Rivotril was however listed in the summary of the clinical chart that was also given to Mr Watson and passed onto BUPA staff. That summary was dated 8 April 2010.

It is relevant that when the use of that drug had been temporarily discontinued in June 2011, Ms Watson suffered severe chorea symptoms after about 7 days leading to it to being recommenced.

Admission to BUPA Kempsey

At about 10.00am on Thursday 10 November, Mr Watson took his wife to the BUPA Aged Care Facility in Kempsey for the pre-arranged three week respite stay while he was to be in Sydney. He provided the staff there a copy of the care plan, a power of attorney and the ACAT assessment. He also provided the medication list signed by Dr Smith and the medical summary given to him by Dr Smith a few days before. The medications list contained instructions to perform a urine ward test every two to three days, and if the results were positive to nitrates, to send a mid-stream urine specimen for further pathological tests and to commence Ms Watson on Keflex, an antibiotic, to combat UTIs.

Beryl was taken into the recreation room by a nurse while Mr Watson was taken to Beryl's room where he unpacked her belongings including, incontinence pads for day care and overnight; fluid thickener; a stick blender for make Ms Watsons food into a puree; mugs and a spoon for feeding her and a sleeping bag in which she usually slept. He also provided a tube of Aristocort ointment in case she developed a rash as a result of urine being on her skin. However, it seems this ointment may have been prescribed for Mr Watson as it had his name on the label.

He went through the care plan with Registered Nurse Wendy Perrett. It noted Beryl needed medication to treat the chorea "*which she cannot miss*". It indicated that a complete list of the medications would be provided. The care plan also noted that "*She gets UTIs very easily and requires at least 1.5 litres of fluid a day in winter and 3 litres in summer.*" Noted on the care plan next to this; "*FBC (fluid balance chart) please.*"

Mr Watson also gave to the staff at BUPA bottles of all of his wife's medication. He says he had checked the contents to ensure they contained sufficient doses she would need for her 21 day stay. He says the prescriptions for those medications were also in the toiletry bag containing the drugs. The RN Perrett recalls being given the bag of drugs but did not check the contents of the bag.

Mr Watson then waited with his wife expecting to provide the staff with a detailed hand-over but he was told this was not necessary.

Mr Watson is adamant that when he left his wife at the BUPA Aged Care Facility on that day she was in good health and did not have a urine rash.

Conversely, the nursing notes record that upon her admission, Ms Watson had "*whole body rashes (red spots) especially on upper arms. Has redness on back of both thighs left heel sacrum and near back passage*". The facility's Care Manager, Ms Donna Farrer, says that on the day of Ms Watson's admission, one of the nurses called her to look at Ms Watson's back and buttocks on account of concern about the condition of her skin. Ms Farrer says that on examination she saw Ms Watson "*had extensive red dry rash on the area described (in the notes reproduced above) and smelt strongly of urine*". Ms Farrer says photographs were taken as a reference point

to see if the rash got better or worse. She says she didn't think it was necessary to call for a doctor to examine the injury because she believed they would be able to treat it. She says she did not inquire and was told nothing further about the condition during the rest of Ms Watson's stay.

The photographs were tendered into evidence. They show numerous red blotches scattered all over Ms Watson's back. Mr Watson is adamant those marks were not present when he took his wife to the BUPA facility. He says, from his experience, the rash developed so far up his wife's back as a result of her lying in urine soaked clothes, rather than sitting upright in accordance with his care plan.

The photographs taken on the day of Ms Watson's admission also show severe but healing pressure areas and what one doctor who gave evidence described as granulated tissue. That witness, Dr Francis, said that, as those wounds appeared to be healing, there would not have been any need to obtain medical treatment for them at that stage. An independent geriatrician who gave evidence, Associate Professor Rosenfeld, expressed the view that the rash in the photographs appeared to have been present for more than a day.

At the time of her admission, Ms Watson weighed 44.1kgs.

Later that day, a nurse from the aged care facility telephoned Mr Watson to advise that Dr Smith had apparently forgotten to sign one of the forms they needed, a medication chart showing each of the medications and the amount and frequency of the dose. Mr Watson called the surgery and was told that it had been taken care of. The next day, staff from BUPA faxed Dr Smith's surgery requesting he provide Ms Watson's signed medication chart that would provide authority for them to administer to her the prescribed medication.

It seems that the next day, 11 November, it also became apparent that there was a discrepancy between the care plan, which listed Rivotril among Ms Watson's medications, and the medication list that had been provide by Dr Smith, which did not. A nurse rang Mr Watson about that. He again rang the surgery and was told that they had also been contacted by the BUPA facility and the matter had been resolved. Mr Watson agrees that he did not specifically mention that the concern related to Rivotril when he rang the surgery.

In the absence of the signed medication chart, the nurses at the BUPA facility commenced dispensing to Ms Watson the drugs listed on the medication list and recording that, either in the progress notes - *"meds given as per transfer letter"* or *"meds given as per medication summary"* – and/or by making notes on a copy of the medication list.

The notations are difficult to decipher, however it is far from clear that between 10 and 14 November each of the medications was given with the frequency shown on the medication list.

Fluid balance charts were also created, and completed on some but not all of the days on which Ms Watson stayed at the BUPA facility. As detailed below, there is a basis to question whether Ms Watson was given 1.5 litres of fluid on *any* day.

On 11 November the Aristocort ointment was applied to Ms Watson's rash. Her fluid intake is not recorded.

On 12 November it is recorded that she received 1240 ml of fluid and that she "*tolerated lunch*".

On 13 November is recorded that Ms Watson received 1170 mls of fluid.

On 14 November she is only recorded as receiving 540 mls of juice and water but as the first entry is made at 1400 hours it is reasonable to assume the record is not complete.

The progress notes record that on the morning of 15 November, the rashes on Ms Watson's lower back were again treated with the Aristocort ointment. Also on that day, Dr Smith's surgery was again contacted in a follow up of the request for a signed medication chart. This was provided and the drugs ordered on it appear to have been given appropriately from that time on. It did not include an order for Rivotril, for the same reason that it was left off the earlier medication list. The fluid balance chart records an in-take of 1020 mls.

A urine analysis was undertaken for the first time on 16 November. It apparently indicated positive for leukocytes and ketones, possible precursors for a UTI but as it was not definitive, no action was taken in relation to it. The fluid balance chart only records an in-take of 380 mls on this day but again as there are only entries for 1.00, 8.00 and 12.00 it might be speculated that other fluid was given and not recorded.

Similarly, fluid totalling 310ml is only recorded as being given at 8.00, 10.00 and 12.00 the next day, raising a presumption that not all fluid given was recorded.

The medical chart indicates that on 18 November a box of Nexium was ordered from a local pharmacy. It was a drug that had previously been prescribed for Ms Watson and used to treat nausea.

Ms Watson seemed relatively settled for the first week or so of her stay at the BUPA facility. However, from about 20 November onwards, it appears this changed. An entry at 10.00am on that day records "*Found her moving herself out of chair. Transferred her back to bed due to safety reasons*". On the evening of that day, there is an entry "*Unsettled, biting at draw-sheet, Panamax given*". At 5.00am the next morning it is recorded "*Very unsettled night. Making loud noises disturbing other residents. Scratching at self. Buttocks very excoriated-urine*".

It is recorded on 21 November that at 2:20pm "*Beryl remains unsettled, writhing in bed and making noises*" and "*swallowing food and drink is very difficult for Beryl*". The fluid balance chart records minimal intake. A urine analysis was undertaken. It showed slightly increased levels of protein which were interpreted as not sufficient to indicate a UTI. Pessaries were used in case Ms Watson's agitation was due to vaginal irritation. It is noted at 16.30, "*Tried contacting Beryl's MO but was unsuccessful.*"

The nurse involved, Christine Anderson, spoke to Mr Watson. She is adamant that she told him about his wife's condition and asked him whether he wished his wife to be taken to hospital, an offer he declined, explaining she was probably "*cycling through her medication*".

On 22 November the notes record; "*Beryl coughing on Weetbix and Allbran...given porridge and prune juice with success*".

A nurse who was involved in feeding Ms Watson says she did so with a feeding cup even though Mr Watson had provided a spoon for the purpose. Unconvincingly, the nurse said she chose not to use it for fear of it injuring Ms Watson's mouth. She agreed that feeding by spoon was very time consuming.

Later than day a further attempt was made to contact Dr Smith. An initial attempt at phone contact was unsuccessful. A fax was sent from the BUPA facility to Dr Smith indicating; "*Beryl very agitated at times.*"..."*Beryl's verbal outbursts also very disruptive for other residents.*" It seems this caused Dr Smith to phone the facility and he agreed to prescribe the Rivotril that had in error been left of the medications list and the medications order previously provided. This commenced to be given the next morning, apparently with good effect.

It is unclear what Dr Smith was told about Ms Watson's condition in addition to what had been included in the fax quoted above. He assumes he was told she had not been on Rivotril but also believes that he concluded the symptoms that prompted the contact from the BUPA staff members were caused by a UTI. He said he did not drive down to Kempsey to see her because it was an hour away and he believed he needed visiting rights, which he did not have, to treat patients in the BUPA facility. Dr Smith said had he been advised that Ms Watson's food and fluid intake was as low as is recorded in the chart, he would have arranged for a visiting medical officer to see her.

On the afternoon of 23 November it was noted that the inflammation on Ms Watson's buttocks and genital area had worsened and so the antibiotic Keflex was commenced on 24 November

Over the ensuing days, Ms Watson continued to receive all of her prescribed medications. On a number of occasions she also received zinc and castor oil on her buttocks on account of the urine rash. On 25 November it seems she drank only 680 mls between 7.00am and 8.00pm.

On 27 November it is noted; "*buttocks very red with skin peeling off. Zinc and castor oil cream applied*".

On 28 November it seems Ms Watson received 1310mls of fluid between 1.00am and 9.00pm. This was more than she seems to have been receiving and is perhaps one reason that at 10.40am "*Beryl (was found) choking on white frothy sputum (that) required suctioning.*" Her buttocks were described as excoriated and zinc cream was applied.

There are two fluid balance charts dated 29 November: one purporting to record intake from 1.00am to 1.00pm, the other apparently relating to the period 8.00am to 5.00pm. Accumulating the entries on both gives a total of 1070mls. In an entry made at 1.00pm, Ms Watson's buttocks are again described as excoriated and it is noted that she is "*holding food in her mouth but accepting small amounts of thickened fluid.*"

The next day it is noted; "*Food and fluid in-take poor, holding liquid in her mouth.*"

The next day, 1 December, her condition was much the same. Her buttocks were still inflamed. When Mr Watson came to collect his wife at about 1.00pm he found Nurse Perrett suctioning frothy white mucus from her throat. Both agree the nurse told him he should see Dr Smith as on-going suctioning would be necessary and he would need to hire the necessary device. Nurse Perrett also says she told him he should take his wife to the doctor for a general check up. The entry in the progress notes simply says; "*Clive may take Beryl to the doctor and suggested he hire suctioning equipment.*"

Mr Watson says he immediately concluded his wife had deteriorated significantly in his absence. He says when he lifted her into the car he could tell she had lost weight. In evidence he said he couldn't estimate how much she had lost but agreed she was not at her minimum weight – she had some time before been as little as 35 to 40 kgs.

Post discharge BUPA

Mr Watson believes that in the day or so after his wife returned home she was dehydrated in that she passed only small amounts of urine.

He also says he noticed a large amount of scarring and loss of skin on her lower back and upper buttocks "*I had never seen anything like it in all the years I cared for Beryl*". He says he could see skin peeling off and open sores. He took photographs of the lesions on the evening of 1 December.

The day after she returned home, 2 December, Beryl ate and drank only a little. It was the same the next day. By Saturday 3 December, Beryl again had a buildup of fluid in the back of her mouth and had to keep her mouth open to breath. Mr Watson scooped some of this out with his fingers and that seemed to provide his wife with some respite.

On Sunday 4 December Ms Watson wouldn't eat anything, but did drink a little fluid. She slept most of the day. It was apparent to Mr Watson that she was sick but he decided that rather than taking her to the Macksville Hospital, he would wait until Dr Smith's surgery opened the next day, because he knew that Dr Smith was so familiar with her case and he didn't want to disturb his wife's sleep which he hoped would be restorative.

On 5 December, Mr Watson took his wife to see Dr Smith. Dr Smith immediately came to the view that she was very sick and required hospitalisation. He arranged for her immediate admission to Macksville Hospital. Dr Smith says it was clear to him that Ms Watson was exceedingly unwell. She was hypertensive and dehydrated. She

had clinical signs of pneumonia. He also noted she had a large pressure sore on her gluteal area.

He rang and spoke to Dr Andrew Lucas at the Macksville Hospital and faxed through an admission letter. He stressed that although Ms Watson had a chronic, severely compromising condition, provided her general health was properly managed, she had a reasonable quality of life in the care of her husband. He is adamant that they agreed that their goal would be to return her to her normal state of health and there was no suggestion that she would be classified “not for resuscitation”.

Admission to Macksville Hospital

When Ms Watson was admitted to Macksville Hospital she was diagnosed as suffering from sepsis due to aspiration pneumonia complicated by dehydration, malnutrition with perineal pressure areas.

The pressure sores were severe but did not seem to be infected. When shown picture of them taken on 28 November and 1 December, Dr Francis was of the view that he would expect to be called to a nursing home if a patient of his had such an injury.

Ms Watson’s low blood pressure and poor urine out-put were symptoms of her dehydration.

She appeared to him to be significantly underweight and he was of the view Ms Watson had been receiving insufficient nutrients for some time.

The pneumonia was confirmed by x-rays which showed consolidation in the upper right lobe of her lungs. Dr Francis was unable to say how long Ms Watson had been suffering from pneumonia but he believed it was likely to have been more than two days. He also expressed the view that the sepsis developed as a result of repeated aspiration of oral food and or fluids.

In his statement, he noted that aspiration is a common complication of Huntington’s disease brought about by the weakness and dis-coordination of the muscles involved in swallowing. He advised that it is often unnoticed and referred to as “silent aspiration”. In evidence he said that being underweight could make a person less resistant to infection. Withdrawing from Rivotril could lead to an increase susceptibility to aspiration. These combined to increase the risk of pneumonia.

Dr Francis says Ms Watson was treated aggressively with broad spectrum antibiotics. At first she appeared to be improving. The option of a transfer to Coffs Harbour Hospital for more intensive intervention was discussed, as was the possibility of alternative feeding methods. However, given her combination of dementia and Huntington’s disease, when she began to deteriorate after being in hospital for about a week “*the family decided to change to a palliative approach to Ms Watson’s care on 14 December*”.

She died in the hospital two days later on 16 December. A cause of death certificate listing aspiration pneumonia as the primary cause and Huntington’s disease as the

antecedent cause with malnutrition as an underlying contributory factor was issued by Dr Francis.

Post death responses

After his wife's death, Mr Watson wrote to the Manager of BUPA Care Services in Sydney to express his concern about the quality of care provided to his wife during her stay in BUPA Kempsey.

BUPA undertook an investigation into various aspects of Ms Watson's care and produced a report containing some recommendations. The Northern Regional Director of the company, Glen Hurley, wrote to Mr Watson on 13 April 2012 summarising the findings and changes said to have been implemented as a result. In this summary of that letter the numbers of the paragraphs used in it are repeated.

In paragraph 2, BUPA acknowledged that Mr Watson had not been given an opportunity to fully discuss his wife's care needs when she was admitted to the Kempsey facility. The letter said changes had been made to ensure pre-admission meetings were held with the family/carers of prospective short stay residents during which the care needs of the resident would be discussed. Contact would also be established between the facility and the patient's usual doctor. If it were apparent the doctor would not be able to visit the facility, should the need arise, then staff had been advised they should seek to transfer the resident to hospital.

The letter also acknowledged that not all staff had been made aware of the need to follow the care plan provided by Mr Watson. It was explained that a new admission process had been developed that would ensure short stay residents in future be admitted using the same documents and processes applied to the admission of permanent residents, including the development of a full care plan and a structured handover upon discharge.

In paragraph 3.1, the letter rejected Mr Watson's claims his wife had not been adequately hydrated or fed during her stay, claiming that fluid intake was monitored and that she only had poor food intake on one occasion.

In response to Mr Watson's concerns about the failure of the facility to provide his wife with medical treatment, the letter claimed in paragraph 3.2 that *"The doctor was contacted on five occasions (dates recited) but the doctor failed to attend. Staff left messages for the doctor to visit."*

In response to Mr Watson's concerns about the management of his wife's pressure areas and urine scalding the letter asserted in paragraph 3.3 that *"there was no change to the rashes during Beryl's stay"*.

Bupa acknowledged in paragraph 3.4 that the need for the suctioning of sputum from Beryl's throat was a change in her condition that should have prompted a medical review in accordance with the then existing policies. The letter said the need to conform with the relevant policies had been re-enforced with staff.

Mr Watson considered the report did not adequately address his concerns. The evidence presented to the inquest indicates he was right to be sceptical: it seems

clear the assertions contained in paragraphs 3.1, 3.2 and 3.3 and quoted above are not accurate. There is also reason to question whether the reforms described in the letter have actually taken place. These issues will be addressed further in the recommendations section of this report.

As a result of his concerns, on 21 April 2012, Mr Watson wrote to the then NSW State Coroner requesting an investigation into the death of his wife. The State Coroner assumed jurisdiction, and detailed the matter to NSW Police Force for investigation. An expert report was also commissioned. Obviously, as the death was not reported until many months after it occurred, no autopsy could be undertaken but as the cause of death was not in issue that did not compromise the investigation.

Expert review

A report was provided by Associate Professor Tuly Rosenfeld, a consultant geriatrician and physician. Dr Rosenfeld reviewed the material contained in the brief. He made a number of comments about the quality of care provided to Ms Watson by her general practitioner and by the staff at the BUPA Aged Care Facility.

Dr Rosenfeld pointed out that as a result of Ms Watson suffering from advanced neurological deterioration, she was susceptible and predisposed to a range of medical problems, complications and adverse events. He referred to a European study in which 86% of people with advanced Huntington's disease died of aspiration pneumonia - the cause of Ms Watson's death.

He pointed out that the symptoms and signs of illnesses in patients with conditions similar to Ms Watson's are very different to the same diseases occurring in patients without advanced neurological illness. Conversely, quite minor ailments can be fatal for these patients. This results in an unfortunate combination of circumstances whereby the symptoms are more difficult to detect and their effect can be far more severe.

Dr Rosenfeld advanced the view that Ms Watson had suffered increasing and progressively severe dependency for a number of years. In his view, her prognosis was very poor. *"Her survival up until her death was in my view, very much attributable to Mr Watson's devotion and care, but with a fair measure of good fortune."*

Dr Rosenfeld points out; it is unrealistic to expect such severely compromised patients to prosper in short-term respite care. It is most unlikely there will be a seamless transfer of responsibility, and it is impossible to expect that the level of care provided to Ms Watson by her husband, one on one, could be replicated in a busy aged care facility.

Dr Rosenfeld drew attention to the significance and difficulty of handover and transfer of care in patients similar to Ms Watson. He said it is *"the most consistently problematic and dangerous aspect in health care provision"*.

He was adamant that after receiving Rivotril for the period she had, Ms Watson would have suffered from withdrawal syndrome when it was inadvertently discontinued. Dr Smith was of the view that Ms Watson did not have a Rivotril

dependency because she did not require increasing doses. He therefore concluded she was unlikely to have suffered from benzodiazepine withdrawal syndrome. However, Dr Rosenfeld was adamant the symptoms of agitation, flexure of the hands and seizures witnessed by the nurses and recorded in the chart are consistent with both the loss of the benefits of the drug and the manifestations of withdrawal syndrome.

In his view a patient does not need to be addicted to suffer from this; it is enough that they are settled on a regular dose. This would have led to agitation and increased swallowing difficulty. Further she was deprived of its calming of her involuntary movements. The combined effects of these two changes explains the agitation and distress witnessed by nursing staff from around 20 November onwards. This agitation and unsettled behaviour is likely to have contributed to aspiration and choking and reduced intake of food. As a result, the risk of an adverse aspiration that was already present was exacerbated and the capacity to detect it was masked.

In his view, the withdrawal syndrome is likely to be *“associated with reduced oral intake worsening neurological functions including swallowing mechanism, pneumonia and aspiration pneumonia.”*

He said, *“By the time the Clonazepam was restarted, Beryl Watson was already suffering from the pulmonary infection that then progressed and led to her death”.*

He told the court the regurgitation of frothy white sputum indicated her lungs were congested with aspirated fluid. He considered it likely she acquired pneumonia around this time. As this choking was a significant and new phenomenon, it warranted the patient being seen by a doctor.

While it was appropriate for the BUPA staff to note and attempt to respond Ms Watson’s increasing agitation and unsettled state, they had no easy way of diagnosing its cause. *“Agitation in a non-communicative patient suffering from cognitive impairment (dementia) is a non-specific indicator that may be indicative of a range of problems including pain, discomfort or constipation.”*

In response to specific questions put to him by the court, Dr Rosenfeld said in relation to the care provided by staff at BUPA Kempsey;

In general terms however, it could summarise my view to indicate that the measures taken by the staff and nurses at BUPA in the care of Beryl Watson were appropriate and of a generally acceptable standard.

However, Dr Rosenfeld raised concerns that a medical review should have occurred at some stage during her stay, particularly when her condition deteriorated.

In relation to her food and fluid intake during her stay, Professor Rosenfeld was of the view that *“Ms Watson was provided with food and fluid to the extent that the nursing staff providing her care were able to do so”.* In his oral evidence he expressed the view that the use of a feeding cup is likely to have been counter-productive in a patient such as Ms Watson.

In commenting on the response of the BUPA staff members to Ms Watson's deterioration, Dr Rosenfeld said;

As far as I am able to ascertain from the documents and the statements of staff at BUPA, their responses were appropriate. It would in my view however, been appropriate to more quickly escalate BUPA'S response in the delay of directing medical review. Alternative primary medical care or direct referral to a hospital would have been indicated, particularly in view of Beryl Watson's worsening of agitation, and subsequent need for suctioning.

The photographs of Ms Watson's pressure areas taken on 28 November were shown to Dr Francis when he gave evidence. He described the excoriation as very severe but said there were no signs of infection. He considered the injuries were of sufficient seriousness to have warranted a doctor being called to examine Ms Watson. Associate Professor Rosenfeld was also of that view.

Conclusions

The evidence indicates that by the time Ms Watson was admitted into the BUPA aged care facility at Kempsey for respite care she was nearing the end of her life. I readily accept the opinion of the eminent independent geriatrician who reviewed her case that but for the diligent and devoted care of Mr Watson she probably would have died sooner.

I also accept that temporary respite care is unlikely to be able to reach that same standard: the patient will be stressed by her new and strange environment; a diminution of the continuity of care with rotating shift workers is unavoidable; numerous professional carers will not understand her needs to the same extent as her life-long partner; and most will be unwilling or unable to meticulously attend to her feeding and hygiene requirements. Accordingly, some deterioration is inevitable.

A few months before her death Ms Watson had weighed only about 40kgs. With assiduous perseverance Mr Watson had managed to increase her weight to over 44kgs when Ms Watson was admitted to the BUPA facility but she was still arguably malnourished and suffering from chronic urine scalding.

It seems likely the Watsons developed a co-dependency that enabled Mr Watson to focus most of his attention on caring for his wife's needs while overlooking evidence of her irreversible decline. In my view she was in a parlous state when admitted to the BUPA facility, even though Mr Watson may not have recognised this.

As is so often the case, a series of cascading mistakes or oversights led to her demise. A break-down in Dr Smith's record-keeping caused an essential medication, Rivotril, to be omitted from the list he provided to Mr Watson for use by the BUPA nurses. This wasn't initially detected by the nurse managers or nurses at the facility even though there was an obvious conflict between the medical summary, the medication list and the care plan with respect to Rivotril.

Dr Smith was tardy in responding to a request for a signed medication order and when he did provide it, Rivotril was again inadvertently omitted.

Because those caring for Ms Watson were so unfamiliar with her, they did not recognise the increased chorea was due to the loss of the prophylactic effects of the drug and the agitation and seizures were caused by benzodiazepine withdrawal syndrome.

When Dr Smith became aware that his patient had been without this medication for 12 days he did not respond to the risks this may have exposed her to, other than by ordering the drug be recommenced.

In my view it is likely that one of those risks, aspiration, did eventuate during this period or in the days before Ms Watson was re-established on her anti-convulsant medication. The failure of nursing staff to fully acquaint themselves with Ms Watson's special care needs and to ensure she received adequate hydration and nourishment is likely to have increased her susceptibility to infection and exacerbated its impact.

By the time she was seen by a medical practitioner, the infection had intensified and become entrenched so that in her debilitated state even intensive antibiotic treatment could not reverse the septic process. While it was the combination of a number of unintended omissions that actually led to her death, it seems clear Ms Watson could have died at any stage, no matter who was caring for her, if this infective process had taken hold.

Although in his written report the independent geriatrician briefed by the Court indicated the care of Ms Watson during her stay in the BUPA facility was of an acceptable standard, that opinion was based on the documentary evidence that was shown by the oral evidence to be inaccurate in some respects. Further, Dr Rosenfeld expressed concern about delay in the obtaining of medical attention when Ms Watson's respiratory condition deteriorated.

While there is absolutely no evidence of callous disregard, it was apparent that a small number of nurses were required to care for a large number of patients. Adapting to the high needs of a new, short-term non communicative patient posed challenges the staff struggled to meet. Two doctors who reviewed photographs of Ms Watson's pressure areas taken near the end of her stay at the BUPA facility said her skin condition should also have prompted a medical review. Further, the urine screens ordered by her GP were not carried out as directed.

I conclude that the care received by Ms Watson during her stay in the BUPA facility was inadequate in some respects. However, the condition that led to her death was difficult to detect and she could have died from it at anytime, anywhere.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died was Beryl Joyce Watson.

Date of death

Ms Watson died on 16 December 2011.

Place of death

She died in Macksville, NSW.

Cause of death

Ms Watson's death was caused by aspiration pneumonia, associated with Huntingtons Disease.

Manner of death

The death was from natural causes, contributed to by a medication error and sub-optimal nursing care.

Recommendations

Pursuant to s 82 of the *Coroners Act 2009*, Coroners may make recommendations connected with a death.

In this case, the inadequacies in some aspects of the nursing care and the management of Ms Watson's admission and discharge warrant consideration from a prevention perspective. In particular, the evidence detailed earlier shows there is a basis to be concerned about the following matters:-

- **Inadequate admission procedures** failed to ensure either that all staff were aware of and required to follow the care plan prepared by Mr Watson and/or that a care plan was developed and followed by the staff;
- **The resulting failure to adequately assess** Ms Watson's need for specialist allied health services and medical review and the failure of staff to ensure Ms Watson received adequate hydration and nourishment; that her skin care was appropriately addressed and her urine screened as directed by her doctor.
- **Prescribed medication was not given** to Ms Watson for the first 13 days of her admission because of clerical error by her doctor that was not responded to with sufficient urgency by BUPA staff members. The indications of her decline on account of her missing that medication were initially overlooked and even when they became more severe a medical review was not arranged.
- **The discharge hand-over** did not give Mr Watson sufficient information about his wife's deterioration during her stay to enable him to make an informed assessment of how he should manage her health care and so he delayed seeking a medical review for a further three days.

In a detailed submission on behalf of BUPA its lawyers did not cavil with any of the findings of fact urged on the Court by Counsel Assisting and acknowledged its obligation to continuously review its policies and their implementation to ensure the residents of its numerous facilities around the country receive an appropriate standard of care.

BUPA's submission also informed the Court that it had, since Ms Watson's death, undertaken an extensive review of the policies relevant to the issues identified as having contributed to a break down in the provision of quality care to Ms Watson. Attached to the submission were copies of those policies and a training timetable for the staff members of the Kempsey BUPA aged care facility.

On their face those new policies would appear to address the concerns identified by this inquest. Certainly, there is no evidence before the Court on which it could conclude they are not an appropriate response. However, there are aspects of this case that cause me some disquiet.

When the Northern Regional Manager of BUPA wrote to Mr Watson in April 2012, he assured him his concerns were either without foundation in fact, or those which were valid had been addressed by remedial changes made since the death. However, evidence given to this inquest calls into question the reliability of both assertions. As detailed earlier, it seems likely Ms Watson was not adequately hydrated or fed and her pressure sores were poorly managed. The attempts by BUPA staff to contact her doctor were not as urgent or persistent as claimed or as they should have been. Further, the centre manager said in evidence the policy changes outlined in the letter to Mr Watson requiring the development of a full care plan for all short stay residents and ensuring a doctor was available to visit such residents had been implemented. However, two of the nursing staff who have worked at the centre for many years and continue to do so said in evidence they were not aware of any changes in these areas. In those circumstances, relying on the bare assertion of BUPA's lawyers that the problems have *now* been fixed could be characterised as unduly credulous.

The Office of Aged Care Quality and Compliance focuses on quality and improvement of the care and services provided to the recipients of Australian Government subsidised aged care services. I intend forwarding to that office a copy of this report with a recommendation that it review the implementation of the policies attached to BUPA's submission

I close this inquest.

M A Barnes
NSW State Coroner
Glebe
23 May 2014