QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of a residential aged care facility resident (a resident)**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	19/09/2024
FILE NO(s):	2023/880
FINDINGS OF:	Carol Lee, Coroner
CATCHWORDS:	CORONERS: Residential Aged Care Facility- Management of Semi-Mobile Residents with Dementia- Environmental Hazards- Compliance with Observation Requirements- Heat Stroke.

Table of Contents

Introduction

The resident was born in New South Wales and died on 18 February 2023 at a regional Hospital (Hospital).

Queensland Police Service (Police) reported the resident's death to the Coroner, because his death appeared to be a violent or unnatural death and fell within the definition of a reportable death in the *Coroners Act* 2003.

The role of a Coroner is to investigate reportable deaths to establish, if possible, the cause of death and how the person died. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

Circumstances

The resident was an 85-year-old retired man who resided in a regional residential aged care facility (Facility). His medical history included:

1. Mixed Alzheimer's and vascular dementia
2. Secondary parkinsonism
3. Hypertension
4. Type 2 diabetes
5. Moderate aortic stenosis.

The resident mobilized by wheelchair and had a history of falls. His wife lived nearby and would visit him regularly.

At approximately 12:18 hours on 11 February 2023, the resident was located unconscious in an unsheltered patio area at the Facility. He was found on the concrete in the sun and was noted to be hot to touch. According to information given to Police, he was last seen at around 10:00 hours.

Emergency Services were called, and Queensland Ambulance Service (QAS) attended at the scene. The resident's condition was described as follows:

1. Unresponsive (GCS 3)
2. Respiratory rate of 40-50 breaths per minute
3. Reduced oxygen saturations of 80%
4. Rapid pulse of 150 beats per minute
5. Hypotensive with systolic blood pressure of 60mm Hg
6. Hyperthermic with first reading 'HI' and second temperature 41. 7 degrees Celsius
7. Hyperglycaemic at 13.2
8. Erythema to his right foot
9. On QAS arrival, he was being actively cooled with wet towels, ice packs and fan.

The resident was taken to Hospital for further management. At presentation he was still hot with a temperature of 40.6. His blood pressure had increased but he was still tachycardic and tachypnoeic. He had warm extremities, swelling and duskiness over his left wrist and hand, erythematous right foot and erythematous rash over the abdomen, thighs and arms. The changes were of uncertain nature but considered to be possible burns.

Blood tests showed:

1. Elevated CK (a marker of muscle damage which can be seen in the setting of

hyperthermia).
2. Elevated troponin (a cardiac marker which can indicate cardiac damage but can also be elevated in heat related illness).
3. Elevated potassium - although there was some haemolysis of the sample limiting interpretation.
4. Elevated urea and creatinine (markers of kidney injury).
5. Overall white cell count was not elevated, however he had mildly elevated lymphocytes.

Chest x-ray showed no evidence of pneumonia, and a CT head scan showed no acute pathology.

Despite cooling and additional treatment, the resident did not show significant improvement. Following discussions with his next of kin, it was agreed to treat him with comfort cares. The resident died in Hospital on 18 February 2023.

Following an investigation, Police did not identify any suspicious circumstances surrounding the resident's death.

Forensic Pathologist's Examination

An external examination, and imaging, document review and toxicology studies, were undertaken.

The opinion of the forensic pathologist as to the cause of death is based on consideration of the circumstances of death and a post-mortem examination including associated imaging and testing.

The forensic pathologist summarised the findings on examination as follows:

1. External examination showed a light skinned elderly man with evidence of recent medical therapy.
2. There were a number of erythematous patches, on the left upper limb, bilateral lower limbs and abdomen. Peeling skin was noted on the left posterior wrist suggestive of a ruptured blister. Blisters were noted over the left foot and second toes, right ankle, foot and toes measuring up to 160mm in size.
3. There were some minor healing sores but no other significant signs of fall related trauma. There was a 12mm pressure sore over the sacrum, covered by a dressing.
4. Postmortem CT scan showed atrophic changes in the brain in keeping with the known history of dementia. There was extensive vascular calcification including the coronary arteries, aorta and peripheral vessels. The lungs show dependent changes of opacification which may reflect terminal aspiration changes.

The forensic pathologist commented that heat stroke is a heat related illness that involves elevated body temperature of greater than 40 degrees Celsius, along with central nervous system dysfunction including reduced level of consciousness. It can lead to organ damage including renal injury and muscle damage. Other signs include rapid heart and respiratory rate. Elderly individuals, particularly with comorbid medical conditions, can be at increased risk of developing heat stroke and these features were all noted clinically in this man.

The areas of erythema and blistering would be consistent with burns. A possible explanation is sunburn on exposed areas of skin however it is unclear what he was wearing at the time he was located to explain the distribution of the affected areas.

It is unclear what has caused this man to collapse to the ground. It may be primarily a heat related event, mechanical fall, or medical event, such as a faint, cardiac event or underlying illness such as infection.

On presentation to Hospital, he had a number of findings that would be consistent with heat stroke. Limited investigations showed no other definite cause for his condition, although these tests were not exhaustive in the setting of significant comorbidities and a decision to proceed to comfort care.

Given the period of survival, an autopsy may be of limited assistance in further clarifying this, although an internal examination would provide a more complete picture of this man's condition. However, in view of the next of kin objection to internal examination, the coroner determined that an internal autopsy was not necessary.

In the opinion of the forensic pathologist, the probable cause of death is heat stroke. Alzheimer's and vascular dementia, diabetes mellitus and aortic stenosis are considered to be contributing factors as these would all increase his risk of susceptibility to heat stroke and its subsequent complications.

Ultimately in the opinion of the forensic pathologist, the cause of death was:

1(a) Heat stroke

Other significant conditions

2 Alzheimer’s and vascular dementia, diabetes mellitus and aortic stenosis.

Investigation

Following the resident’s death, the Aged Care Quality and Safety Commission (ACQSC) was notified about the incident.

A Serious Incident Response Scheme (SIRS) investigation was commenced by the ACQSC.

A Notice was issued to the Facility on 17 March 2023, requiring provision of the following information under its governing legislation:

1. The outcome of your investigation into this incident, including:
    a. The causes of the incident.
    b. The harm caused by the incident and an update on the consumer’s current condition.
    c. Any operational failures identified that may have contributed to the incident.
    d. Whether the incident could have been prevented.
2. Details of your actions that have been or will be taken to address any gaps in care and services and cause/s identified following your investigation including:
    a. When these actions were or will be implemented.
    b. Your assessment of these actions that will prevent further similar incidents of this kind from occurring, or to minimise harm to consumers at your service.
    c. Your assessment of these actions that will improve the management and resolution of these incidents in the future.
    d. What methods will you use to measure the effectiveness of the strategies that have been or will be implemented.
    e. Your assessment of whether persons and bodies should be notified of this

incident.

3. Details of your response to the incident including:
    a. Your assessment of involving each affected person including the representatives in the management and resolution of this incident.
    b. The involvement of the representatives of the consumer in the management and resolution of this incident.
    c. Your actions on using an Open Disclosure (OD) process as is the requirement under 15LA (2)(e) of the Quality-of-Care Principles; including whether the consumer had a Medical Decision Maker or Enduring Power of Attorney (EPOA); if so, were they consulted during this time.
4. Outcome of the hospital assessment of the consumer.
5. You have stated in your notification to the ACQSC that you are providing further education to staff. Provide details, including:
    a. What is included.
    b. When did/will this take place.
    c. How many staff have/will attend this training.
    d. How will you measure its effectiveness.
6. In addition to the above, clarify *'The resident was allowed to make his choice to mobilise on a wheelchair around the facility. This was a dignity of choice that was discussed and agreed with his EPOA* [the resident's wife]*',* as set out in your notification to the ACQSC.
7. Furthermore, policies and procedures on how incidents are identified, recorded and reported to the SIRS, as per mandatory reporting legislation.

The Facility responded to the Notice on 24 March 2023 as follows, adopting the corresponding numbering above:

1. The outcome of the investigation of the incident on 11 February 2023:

    a. In line with the resident's Mobility and Transfer care plan, he mobilized himself about the Memory Support Unit (MSU) (where he lived) in his wheelchair. On the morning of the incident, the resident mobilized himself outside the building onto a garden patio area in a position that was not easily visible to those inside the Facility. He remained in this area for 2 hours and 18 minutes. The area had no shade, on the day of the incident the temperature was approximately 30°C, and the resident had no sun protection except for the clothes that he wore.
    b. The resident was in an external unshaded area for a prolonged period of time, and the following clinical assessment was provided by a General Physician and the Hospital, detailing the medical outcome for the resident: [The resident] *had signs of significant environmental exposure injury on presentation to the hospital. On examination, his injuries included significant hyperthermia (41.7°C), apparent sunburn of the face and abdomen and severe blistering/burns of the skin of the left wrist and left lower leg.* [The resident] *passed away on 18th February 2023.*
    c. The resident was on hourly sight charting. This care measure ensured that the resident was physically sighted by an Assistant in Nursing (AIN) every hour to confirm his safety and his location. This aspect of the resident's care was not conducted for the 11:00 hours sighting on 11 February 2023. The resident was sighted at 09:57 hours and next at 12:18 hours. A search for the resident commenced at 12:00 hours when the Registered Nurse (RN) sought to locate the resident for his 12:00 hours medications. When the RN could not locate the resident in his room at 12:00 hours, a search was immediately commenced to locate him. Staff located the resident on the outdoor garden patio at 12.18 hours.

d. This incident was preventable. The prescribed nursing action of hourly sightings would have maintained the resident's safety and wellbeing.

2. The actions taken to address identified gaps in care and services are as follows:

a. **Hourly sightings/charting of residents**

i. Staff education on the importance and reinforcement of timely completion of sighting charts. Staff education was commenced on 14 February 2023 and was conducted by the Care Director (CD) over a number of days at the Care Staff Huddles at 10:00 hours and 15:00 hours each day. The education session will continue until 100% of staff have completed the education session. Staff education included:
   1. The requirements of the AIN in performing this task.
   2. The Health Metrics documentation requirements.
   3. The importance of this task being conducted accurately.
   4. The elements of providing a safe environment to residents with Dementia.

ii. The process of the hourly sighting of wandering residents will be expanded. The hourly observation will also be conducted with another (second) AIN from another section of the Facility. This second AIN will be nominated at the beginning of each shift on the Staff Allocation Sheet. This second AIN will work collaboratively with the first AIN allocated to the MSU Residents to ensure that the sightings are conducted in a timely manner. The revised is in effect a 2-person authentication process. The revised process will include documentation of the presence of the second AIN who will be present for the sighting, and this will be added to the Health Metrics sight charting.

iii. The hourly sightings for this care area of the Facility will also include a physical check of the outside garden areas by the AIN for the MSU.

The combination of these strategies will ensure a robust method of preventing any re-occurrence of an incident of this nature and minimize the risk of harm to any resident in the future. The use of the 2-person authentication for this wellbeing/safety check will ensure that the task is consistently conducted. The sight charting will be checked by the CD/ RN to verify that the 2 AINs are conducting the sighting as per process. The implementation of this strategy has commenced with staff consultation, development of the revised process and a trial will commence on 27 March 2023. The staff consultation has been vital in securing a 'real solution' facilitating the timely and mandatory sighting checks.

b. **Alarm to Outside Door**

An alert on anyone exiting the door into the MSU garden area has been identified as another improvement option. This strategy was quoted, and the product selection refined to meet the needs of the Facility. Cablecomm prepared quotes and specifications, and this has been approved to proceed.

This alarm system will be attached to the 2 doors that exit from the building into the outside garden area. The alarm will be activated once the door is opened. The system will then activate the nurse call system, the phone carried by the AIN and the Annunciator in the Unit. This alarm will only be

able to be deactivated if the staff member goes to the door and turns it off. This alarm system will be another check for staff to ensure residents are not in this outside area for any long period of time and are not in this area without staff being aware they are there. The hourly sight chartings will compliment this strategy providing staff with a strong system for monitoring the whereabouts of wandering residents.
This strategy can be assessed for effectiveness via review of the Nurse Call Reports. The reports can be analysed for the time it took for a staff member to answer and check the doors. CCTV can be analysed to verify the actions taken in response to the alarm activation. The CD will monitor these reports.

c. **Assessment of the Physical Environment Outside the Building Perimeter**

The incident and its occurrence in the outside garden area has been referred to the Workplace Health and Safety Team and the Property Team. These teams from the Facilities' central services are conducting an assessment on the areas for any consideration for further rectification measures to ensure resident safety at the Facility.

3. Response to the incident:

    a. The resident was immediately transferred via ambulance to the Hospital after being attended to and assessed by the RN on duty. The CD and the Executive Director (ED) maintained communication with the Hospital and the resident's EPOA – the resident's wife. Staff were unable to communicate directly with the resident as his condition was one of varying levels of consciousness, from unconscious to rousable to voice.
    b. The ED telephoned the resident's wife personally on a number of occasions to offer both sincere apologies for the incident and inquiring as to her personal wellbeing. The resident's wife gave the Facility regular updates on the resident's condition. The resident died on 18 February 2023 in the Hospital. At this time, Police were notified by the Hospital.
    c. The Facility has cooperated with all requests by the Police and the Coroner.
    d. On 10 March 2023, an OD meeting was conducted with the resident's wife, with this having been offered to the resident's wife to be conducted at any time that she requested. The resident's wife chose the date of 10 March 2023, and the Facility accordingly respected her preferred date. The resident's wife attended the Facility, supported by another family member. The meeting was attended by ED and Regional Manager (RM). This meeting covered both the investigations which were currently still ongoing and provided to the resident's wife a pictorial presentation of the resident's movements at the time of the incident, from still photos from the CCTV footage. The meeting concluded with the resident's wife's request to be informed of any outcomes of the investigations; a request that will be respected by the Facility. A follow up meeting was to be organized.

4. Outcome of the Hospital's assessment:

    a. The resident remained in the Hospital until his death on 18 February 2023. A report from the Hospital was supplied.

5. Education:

    a. Staff education on hourly sighting of wandering residents commenced on

14 February 2023. This included:

i. The requirements of the AIN in performing this task.
ii. The Health Metrics documentation requirements.
iii. The importance of this task being conducted accurately.
iv. The elements of providing a safe environment to residents with Dementia.

b. As at the date of the response, 21 staff had attended this training conducted by the CD at care staff huddles at 10:00 hours and 15:00 hours each day. All staff will attend this education. There are 34 AIN staff presently employed.
c. This process will be included in Agency staff orientation to the Facility, and in the onboarding for all new staff. In addition, RN's will be included in the education to ensure they can reinforce the messaging and provide oversight of the practice.
d. The effectiveness of this education will be assessed on 31 March 2023. The CD will individually assess the knowledge base of the AIN staff. This face-to-face assessment will quiz staff about this task/skill.
e. Monthly assessment will be completed on 28 April 2023 and 30 May 2023 to assess the ongoing retention of the AIN's knowledge base from this education.
f. The CD will also conduct an audit each month to assess the skills, competency, and compliance of all staff with the completion of the sighting charts. This audit will be first conducted on 31 March 2023. The results of this ongoing audit will be tabled for discussion and review at the Monthly Clinical Meeting. This information will also be added to the Monthly Clinical Data Analysis Report which is considered by the Quality Business Partner at a regional level.

6. Clarification about the resident's choice to mobilize:

a. The resident lived with Vascular Dementia and Parkinson's disease. On his admission, the resident was initially cared for in a low low bed to maintain his safety as he liked to move around although he could not weight bear for transfers. Over a period of time with the assistance of physiotherapy, the resident experienced improved mobility and was able to stand transfer to a wheelchair which he self-propelled.
b. The resident was a man with a very determined manner, and he was not easily distracted from an activity that he wished to pursue. The resident's behaviours could progress to verbal and/or physical aggression. The resident frequently refused cares such as hygiene attention, and assistance with meals and drinks. When the resident refused these cares, the staff would give him space and time to process his options. Most of the time the resident would do what he chose to do. This choice was respected by the staff as he had clearly not consented to the activity.
c. The resident's mobility and transfer plan was discussed with his EPOA [the resident's wife]. It was agreed that it was reasonable to support the resident's preferred movement about this Facility. This supported his choices for his daily activities and engendered his purpose of life.
d. The resident's wife agreed with this plan of care and in allowing this dignity of risk, all aspects of the consequences of this plan and any possible options were discussed with the resident's wife.

7. Policy:

a. The following policies were supplied to the ACQSC:

i. Incident Management Policy.
ii. SIRS Portal User Guide.
iii. Incident Reporting Flowchart.
iv. SIRS Investigation Report.
v. Feedback, Complaints and Open Disclosure Management Policy.

On 9 August 2023, the ACQSC requested an update to the implementation of the above actions taken on behalf of the Facility.

On 17 August 2023, the Facility responded to the ACQSC with this information; a summary of which is as follows:

1. The Facility conveyed that it is deeply saddened by this incident. Staff have met with the resident's wife on three formal occasions (including a morning tea) and many informal occasions as part of the resident's wife's continued wish to remain included within the Facility family.
2. The Facility has implemented a number of improvements to prevent such an incident occurring again, and thanks the ACQSC for the opportunity to report on the progress of these changes and the effectiveness of the strategies.
3. Twelve attachments were provided to evidence the actions taken.

Staff Education- Hourly Sighting Charting of Residents

1. Staff education of hourly sighting and charting of residents was commenced on 13 February 2023 and continued until 31 March 2023 when 100% of employees' education was achieved on this topic.
2. From 27 March 2023, the procedure for hourly resident sighting was modified to involve 2 employees per shift, ensuring consistent and reliable monitoring. This enhanced approach is documented in the Daily Allocation Sheet.
3. This task was further reviewed after it was implemented. To augment the accuracy and timeliness of the sightings, employees have been equipped with alarm bracelets from 20 April 2023. These bracelets emit an alarm every hour, serving as an additional reminder to undertake hourly resident sighting. This enhancement not only ensures the reliability of the resident sighting process but also reinforces the employees' awareness and commitment to their responsibility.

Revised Hourly Sighting/Charting Process

1. The measures comprise the revised and expanded hourly sighting process implemented at the Facility. The trial of this revised and expanded hourly sighting process has been evaluated as being 'fit for purpose' to achieve appropriate care outcomes. The aim of the 2-person authentication is to ensure that the hourly sighting always takes place. Having 2 people assigned to this task ensures that the residents are always covered if one employee becomes ill, or if one employee is called away to another urgent activity. The process encourages collaboration between the 2 employees, for example by telephoning each other. The 2-person authentication is akin to the 2-person medication administration which takes place for certain drugs of dependence (Schedule 8). The 2-person authentication process, together with alarm bracelets for the employees, adds a framework around the hourly checks.
2. The trial ran from 27 March 2023 until 30 May 2023 when it was agreed (in consultation with employees) that the hourly sighting of residents would now permanently include:
    a. Use of 2 employees for sighting procedure
    b. Daily allocation of employees to this task

    c. Use of alarm bracelet for hourly alerts
3. This revised process for hourly sighting was communicated to employees via memos, and face to face education by the CD. New Employees joining the Facility will be educated on this process during their orientation with the CD. An orientation booklet that is given to new employees and agency employees has been updated to include the details of this process.
4. The effectiveness of this revised procedure is captured via the use of ongoing analysis by a senior clinician:
    a. Employee Interviews- these are conducted monthly by the CD and evaluates employee knowledge and skill about the hourly sighting / charting procedure.
    b. Hourly Sighting Audit- conducted monthly by the CD and evaluates employee compliance with the procedure.
5. The results of these evaluated strategies are tabled and discussed at the Clinical Meeting and Clinical Data Analysis Meeting, monthly.
6. The outcome from the last 4 months' analysis reveals that employees are competent in the process of hourly sightings of wandering residents and are compliant with the process. Wandering residents are identified and the hourly sightings are allocated in the Health Metrics Logs.
7. AIN employees perform the task and resident safety and wellbeing is checked and documented hourly. This robust checking of the resident's whereabouts and wellbeing facilitates the care teams' confidence in maintaining a safe environment for all residents.

Alarm System on Exit Doors to Outside Garden Area

1. This alarm system was installed on 17 April 2023 by CableCom. The alarm is activated once the door from Area D of the MSU Dining Room and the door from MSU lounge are opened. The alarm is activated via the Nurse Call System. The annunciator panels in the MSU corridors display the alarm when it is activated. Employees are also notified via their portable phones of the alarm. The alarm can only be deactivated if an employee goes to the door and turns it off.
2. Employees have been educated on this Nurse Call System revision via a memo and face to face instruction.
3. This new alarm has been an effective strategy in alerting employees of resident movements to the outside garden area. This has eliminated the risk of a resident exiting unnoticed. The employee alerts are functionally complemented by the robust hourly sighting process of wandering residents.
4. The combined strategies facilitate resident's freedom of movement to this outside area while ensuring employees are aware of the location of residents and can monitor their safety and wellbeing. Employees are alerted to the resident's movements so that appropriate checks are conducted. This will include observing:
    a. Ensuring that the resident is appropriately attired for the weather conditions with respect to protective clothing such as hats, long sleeve clothing and sunscreen on warmer days.
    b. Weather conditions and external temperatures are monitored, and water is provided to residents who are outside on warm days.
    c. Inclement weather – e.g., rain

    and implementing appropriate actions to keep the resident safe and comfortable.
5. The CD conducts monthly reviews of the Nurse Call Reports that are issued from the Data Report functions of this system. The reports are analysed for response times. CCTV footage is also regularly reviewed to ensure that employees are responding with alacrity to the door alarm activation. This analysis has revealed that employees respond promptly and check the area for a resident who may have exited unnoticed.

6. These monthly reviews will remain as an important part of ensuring the continued effectiveness of these strategies.

WHS and Property – Rectification Measures to Ensure Resident Safety at the Home

1. The Workplace Health and Safety Team (WHS Team) undertook an investigation and prepared a report regarding the incident, which recommended corrective actions in 3 separate areas, being Equipment, Systems/Processes/Procedures, and Training.
2. In relation to equipment, a recommendation which has been implemented was the installation of the door alert system to notify that a resident has entered the outdoor courtyard area. As indicated above, that alert system has been implemented, and is considered an effective measure. In terms of equipment some discussion was had about adding shade in the courtyard. The Property and WHS Teams concluded that the addition of shade to the courtyard would not address the extensive outdoor area beyond the paved part. It was noted that the outdoor area is navigable by ambulant people/residents well beyond the paved area and extends for a significant length of the building. Rather, in terms of prevention of reoccurrence, it was considered that measures beyond the physical or built environment were likely to be better at achieving the aim of preventing reoccurrence (e.g. the focus on hourly sighting charts and door alarm system). The Property and WHS teams noted that on warm days, residents would be encouraged by employees to use the building's inner courtyard area, which is cooler and shaded. The inner courtyard area is readily accessible by MSU residents, and the MSU at the Facility is not a closed/locked unit, and residents of the MSU have access to that area. Again, it is hoped that this provides some reassurance to the ACQSC regarding residents' freedom of movement.
3. In relation to systems/processes/procedures, the WHS team recommended a review of the effectiveness of the sight charting procedure, and the development of a process for responding to an alarm alerting employees to a resident entering the outdoor courtyard and ensuring that appropriate welfare checks take place. On both those topics, the WHS Team observed that both measures had already been adopted by the Facility. The revision and expansion of the hourly sighting chart process, and the implementation of the alarm system have already been described above. The WHS Team also recommended that water be made available to residents in the outdoor area on warm days. This recommendation forms part of the combined strategy of the welfare checks which take place in tandem with the door alarm system and revised hourly sighting check, which have been implemented.
4. In terms of training, the WHS Team recommended education for employees on sight charting procedures. The WHS Team observed that the education had already commenced and highlighted above. The process of education has been rolled out to all employees and completed in late March 2023. That education will continue for new employees.
5. Input was obtained from the resident's family on the topic of rectification measures. At the OD meeting held with the resident's wife and another family member on 11 May 2023, they were invited to provide their feedback. The resident's wife's ideas were thoughtfully considered for the Facility but were not finally adopted, as they did not fully align with the specific prevention needs of the MSU residents. Nevertheless, the process was valuable in fostering a sense of unity and represented a sincere effort to include the family's perspectives.
6. Ideas which the resident's wife provided included the addition of a handrail to the outdoor fence, addition of an outdoor umbrella, addition of a nurse call bell button to the area, and installation of outdoor monitoring systems, such as a microphone.

7. Some of the resident's wife's ideas could not be implemented for reasons such as privacy (for example, the microphone idea). It was respectfully observed that her recommendations regarding built environment would have been unlikely to have assisted a resident with advanced dementia, and it should be borne in mind that the courtyard area is external to the MSU, so preventive actions need to be directly applicable for residents with severe cognitive impairments. For these reasons, the key rectification measures are aimed at protecting residents with severe cognitive impairments, focusing on the double-authentication process for conducting hourly sighting and welfare checks, and implementation of the staff alarm bracelet for those hourly sighting checks (emphasizing that time is of the essence for those checks to be completed), and installation of the door alarm which triggers the nurse call bell system. These combined strategies are aimed at addressing the risks of being outdoors on warm days for residents with severe cognitive impairments in a memory support environment.

Police Action Taken in Response to the Reportable Incident

1. The Police attended the Facility at 10:00 hours 18 February 2023 requesting information in relation to incident involving the resident. The Facility fully co-operated with Police including providing employee contact details, and CCTV access to assist the Coronial investigation.
2. The Coroner's Court of Queensland (CCQ) also requested documents including medical records.
3. All requests for information from these two authorities were submitted within the designated timeframes.
4. As at the date of the response, the Facility (and the provider) has not had any further contact from these parties since providing the material for the coroner's assistance.

Open Disclosure Meeting with Family

1. Two OD meetings have been held with the resident's family.
2. The first meeting was held on 10 March 2023. The resident's wife attended the Facility supported by another family member.
3. The second OD meeting was held on 11 May 2023 with the resident's wife, another family member, and their legal representative, attending the Facility. This meeting on 11 May 2023 proceeded with all participants in the meeting reviewing the CCTV footage in full. This included the CD and RM.
4. The viewing of the CCTV footage was at the request of the resident's wife. Emotional support and explanation were provided with breaks to continually assess the family's coping mechanisms while viewing the CCTV footage of the resident during the incident on 11 February 2023.
5. The CD and RM confirmed to the resident's wife that a staff member had failed to conduct the 11:00 hour sighting of the resident as procedure directed. The meeting then moved to the area in Area D MSU where the resident had exited the building. The resident's wife was able to be shown firsthand the improvements that have been made, and the steps which have been implemented to prevent the likelihood of reoccurrence of such an incident. These included:
    a. Removal of the internal curtain to improve visibility to the area outside. This was a suggestion from the resident's wife at the initial meeting on 10 March 2023. The removal of the curtain has improved visibility onto the courtyard from the dining room.
    b. Alarm system fitted to the door. This alarm was demonstrated to the family, and they were shown the annunciator panel and staff phones.
    c. The alarm bracelet worn by employees was demonstrated to the resident's

wife. The employees working on shifts that day talked with the resident's wife about its function and effectiveness.

6. The resident's wife was (understandably) visibly emotional but expressed her gratitude for all the improvements that have been made.
7. At the conclusion of this meeting the resident's wife expressed her desire to visit the Facility again to talk with employees with whom she had grown acquainted over the years of the resident's residency at the Facility. This request was fulfilled in part with a morning tea on 23 June 2023.
8. In relation to the acknowledgment above about a failure by a staff member to follow directives regarding sighting, following an internal People and Culture process, a staff member's employment was terminated, and the Facility referred this matter to the Queensland Office of the Health Ombudsman, who is investigating.

After consideration of the above information, the ACQSC determined that the assessment arising from the SIRS was 'complete' on 10 September 2023.

On 28 May 2024, the ACQSC provided the CCQ with this updated information and outcome of the SIRS upon request.

Conclusion

After considering the material obtained during the coronial investigation, I consider that I have sufficient information to make the necessary findings in relation to the resident's death and that an Inquest is not required.

I accept the forensic pathologist's opinion as to the cause of death and find that the cause of the resident's death was:

1(a) Heat stroke

Other significant conditions

2 Alzheimer's and vascular dementia, diabetes mellitus and aortic stenosis.

I find that on the morning of 11 February 2023 at the MSU, the resident accessed an unsheltered outdoor garden area by a self-propelled wheelchair and during an extended period of unmonitored time, suffered significant environmental exposure and injury, resulting in his death at the Hospital on 18 February 2023. For the reasons detailed at length above, this tragedy was preventable and occurred in the context of staff failure to undertake periodic visual safety and wellbeing checks. The incident has been the subject of a comprehensive investigation by the regulator (ACQSC). I note the acknowledgment of the failures on the part of the Facility together with the nature and extent of the significant actions taken by it following the incident and am satisfied that the combined effect of these strategies will prevent a similar incident from occurring again in the future. I also note that the staff member who failed to undertake the critical sight observations has been terminated and has been the subject of a mandatory report to the Office of the Health Ombudsman.

I extend my condolences to the resident's family and friends for their loss.

Findings required by s.45

Identity of the deceased – A residential aged care facility resident

How he died –	On the morning of 11 February 2023 at the Memory Support Unit at the Facility, the resident accessed an unsheltered outdoor garden area by a self-propelled wheelchair and during an extended period of unmonitored time, suffered significant environmental exposure and injury, resulting in his death.
Place of death –	A regional Hspital
Date of death–	18/02/2023
Cause of death–	1(a) Heat stroke *Other significant conditions* 2 Alzheimer's and vascular dementia, diabetes mellitus; aortic stenosis

I close the investigation.

Carol Lee
Coroner
CORONERS COURT OF QUEENSLAND
17 September 2024