MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Wayne Victor Rouse

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Wayne Victor Rouse (Mr Rouse);

b) Mr Rouse died from sudden cardiac death after cardiopulmonary resuscitation (CPR) was not provided to him;

c) Mr Rouse's cause of death was congestive cardiac failure and chronic obstructive pulmonary disease; and

d) Mr Rouse died on 14 June 2023 at Sheffield, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Rouse's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- Report of the Forensic Pathologist Dr Andrew Reid;
- Patient health summary of Mr Rouse obtained from his general practitioner;
- Records obtained from Tandara Lodge Residential Aged Care Facility (RACF);
- Letter from the Director of Nursing of the RACF;
- Report of the Coronial Forensic Medicine Nurse Mr Kevin Egan; and
- Forensic evidence.

Background

Mr Rouse was 68 years of age (DOB 29 November 1954), divorced and an ex-bushman at the date of his death. He resided at Tandara Lodge RACF in Sheffield.

Mr Rouse suffered from congestive cardiac failure, hypertension, chronic obstructive pulmonary disease, he was a smoker, he had suffered from cellulitis of the foot, a chronic foot ulcer and he also had difficulties with incontinence.

Circumstances Leading to Death

Mr Rouse was being treated for a left foot infection on a background of his many medical comorbidities which are set out above. He saw his general practitioner at approximately 4:30pm on 13 June 2023 for the infection, at which time the general practitioner prescribed some antibiotics and conducted checks on his overall health. Nothing unusual transpired after that appointment and Mr Rouse ate his dinner as normal and the RACF's nurses conducted routine checks on him, with the last one being at approximately 11:45pm.

Early the next morning he used his call bell in his room to request assistance but staff were busy with another resident and were only able to attend to him some eight minutes later. Upon arrival staff noted Mr Rouse was unconscious on the bathroom floor and he had no pulse. The emergency call system was used to summons a registered nurse. Staff did not commence CPR as they believed Mr Rouse had an active "do not resuscitate" order, but an ambulance was called. Mr Rouse was pronounced dead by ambulance staff some 15 minutes later. Staff then located the deceased's records and discovered that he, in fact, had an active resuscitation order.

Investigation

The Forensic Pathologist Dr Andrew Reid conducted an autopsy on 16 June 2023. As a result of his examination of Mr Rouse and a review of post-mortem imaging and medical records he concluded Mr Rouse's cause of death was congestive cardiac failure and chronic obstructive pulmonary disease. Congestive cardiac failure is a condition whereby the heart cannot pump well enough to give the body a normal supply of blood. Chronic obstructive pulmonary disease is a disease that causes breathing related problems. In addition Mr Rouse had coronary atherosclerosis and cardiomegaly; that is he had a build-up of plaque or fat and cholesterol on the walls of the heart's two main arteries which caused narrowing of those arteries and an enlarged heart. In addition, Dr Reid says the prognosis for successful CPR following an out of hospital cardiac arrest in a residential aged care facility is poor. In circumstances such as this, Dr Reid says even if CPR is performed death usually occurs. He says in Mr Rouse's case there were multiple risk factors for a sudden fatal arrhythmia. I accept Dr Reid's opinion.

Because of the clear error demonstrated by staff at the RACF I arranged for the coronial nursing consultant, Mr Egan, to consider its records. He notes the following:

- The RACF's documents clearly identify Mr Rouse's treatment choices which included wanting CPR, a transfer to hospital for acute medical support and activation of life-saving measures such as ventilation, kidney dialysis, surgery and tube feeding.
- The nursing handover sheet held by the registered nurse on duty indicated he was not for resuscitation. When the staff carer went to access the medical goals of care plan after the ambulance was called there was no "prefilled form" in the record and the medical goals were not immediately available to clarify the orders.
- It appears the ambulance was called as Mr Rouse was still breathing at the time he was discovered. Although staff believed he was not for resuscitation, the cause of his unconsciousness and whether he had sustained any other injuries were unknown at the time and therefore one cannot be critical of staff calling an ambulance in those circumstances. Once ambulance personnel arrived it was discovered then the goals of care were for resuscitation. By this time 15 minutes had passed with no cardiac output. The likelihood of survival in those circumstances is extremely low.
- On this evening there was only one registered nurse and one care worker rostered to work. It is unclear how many residents the staff were caring for at this time and the usual staffing level is not known. If both staff are helping another resident, as occurred here, there is no-one available for the rest of the unit. This is a risk this RACF needs to address.
- In the RACF's correspondence it is noted a series of changes have been made as a result of this death and the review which has taken place. Quick and easily identifiable resuscitation protocols for each resident have been implemented with multilevel safeguards which include:
    - all residents have an updated and approved goals of care form signed including temporary and respite residents;
    - colour-coded signs in the residents' rooms indicate their resuscitation status;
    - there is standardised and localised document storage in the common staff area for all residents' goals of care documents;
    - there is a quick reference system on the registered nurse keyring to identify those residents for resuscitation;
    - staff education and training has been undertaken to update all staff on the changes made and location of key documents and plan; and

- the not for resuscitation section on the staff handover sheet has been removed in order to eliminate it as a potential source of incorrect information and input error.

Mr Egan says these changes are appropriate and should provide multilevel protection or risk mitigation for all staff working in the RACF. He concludes by saying:

"There is a clear organisational failure at the RACF in the communication of the residents' goals of care. The RACF has identified, documented and implemented a series of changes to address the inaccuracies in their communication and documentation. I believe that the changes made at the RACF will address the issues in communication of the residents' wishes and provide risk management structure for the staff working there. I believe that staff were operating in accordance with the information they had at hand and in good faith."

I accept the opinions expressed by Mr Egan.

Comments and Recommendations

Mr Rouse died in very unfortunate circumstances. He was not afforded CPR which was contrary to his expressed wishes which were documented. The failure to provide this treatment was due to inadequacies in the RACF's documentation and in the communication to staff of a resident's wishes. These inadequacies have been addressed by the RACF and in Mr Egan's view the changes which have been made will reduce the chances of somebody not being afforded CPR, when that was their wish, from occurring again.

Had CPR been provided to Mr Rouse in accordance with his expressed wishes the medical evidence appears to suggest he would not have been revived.

The only **recommendation** I would make is that the RACF reviews its staffing levels and ensures it has adequate staff rostered on to enable more than one resident to be assisted at the one time. It is clear in this case Mr Rouse could not be assisted until eight minutes after he had used his call bell because staff were assisting another resident.

The circumstances of Mr Rouse's death are not such as to require me to make any further comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr Rouse.

Dated: 10 October 2023 at Hobart in the State of Tasmania.

Robert Webster
Coroner