



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Rod Chandler, Coroner, having investigated the death of David Alexander Cobham

Find that:

- a) The identity of the deceased is David Alexander Cobham.
- b) Mr Cobham was born at Melbourne in Victoria on 7 July 1930 and was aged 84 years.
- c) Mr Cobham died on 23 April 2015 at the Royal Hobart Hospital (RHH) in Hobart.
- d) Mr Cobham died as a result of aspiration pneumonia following rhabdomyolysis due to entrapment of his right arm in a bathroom hand rail.

Background

Mr Cobham was a retired master mariner. Since 1956 he had been married to Ruth Mary Cobham. They had two sons, Andrew and Richard, both now adults. In 2008 Mr and Mrs Cobham took up residence at Vacluse Gardens in South Hobart. From around 2009 Mr Cobham began to suffer with a deteriorating memory and he was later diagnosed with dementia. Mrs Cobham died in 2011 following a fall. In June 2014 Mr Cobham moved into The Lodge, a division of Vacluse Gardens designed to accommodate persons suffering with dementia.

Bupa Care (Bupa) is the operator of Vacluse Gardens including The Lodge. It maintained a documented Plan of Care for Mr Cobham. The hygiene portion of the Plan records the following relevant information:

- That Mr Cobham liked to get up each day between 6.00 and 7.00am and to shower before breakfast.
- That Mr Cobham required the assistance of one staff member to help him meet his daily hygiene needs.
- That on 31 December 2014 a sensor alarm was installed in Mr Cobham's room to alert staff that he was out of bed and may require assistance with his hygiene needs.

- That at a review of the Plan of Care on 16 January 2015 it was recorded that *“staff continue to be vigilant in negotiating times to suit David to attend to his hygiene as early as possible.”*
- That indoors Mr Cobham was able to walk unaided.

Mr Richard Cobham has reported that his father made *“a smooth transition”* into The Lodge and despite some weight gain at around this time *“was still very independent and able to do most things unassisted.”*

Circumstances Surrounding the Death

Ms Lesley Simmons is employed by Bupa as an extended care assistant. On 15 April 2015 she was rostered to work the night shift at The Lodge beginning at 11.00pm and concluding at 7.00am the following day. Ms Ashlee Duffy was rostered to work with her. This was her first night shift at The Lodge.

Ms Simmons reports that at about 1.30am on 16 April she went to Mr Cobham’s room to check on him. He was awake and walking back to his bed from the toilet. He told her that he was okay. Ms Simmons next attended Mr Cobham’s room at about 3.30am. This time she *“stuck my head in.”* Mr Cobham was asleep in bed and all the lights were off. She was next due to check on residents at about 6.00am to 6.15am but says; *“I am unsure if I checked David at this time.”* Her shift finished at 7.00am and she went home. In her statement to the coroner Ms Simmons describes Mr Cobham in these terms; *“Before the incident, David was our most independent and mobile resident. David required no aids for walking, showered himself and dressed himself all the time. He was a very happy resident.”*

I need to record at this point that an affidavit has been provided by Ms Lesa Kerstan, the Clinical Care Co-Ordinator at Bupa. She records that in the morning of 16 April 2015 she telephoned Ms Simmons to enquire of the times she had checked Mr Cobham the previous night. She deposes that she was advised as follows:

“She said she last checked him at about 6.45am as he had had an unsettled night and was up at about 4.30am to go to the toilet. She stayed with him at that time until he was settled back to bed.

“Leslie (sic) told me that she checked on him at about 6.45am as usual and he was sound asleep in bed.”

It was the evidence of Ms Duffy that she did not have any contact with Mr Cobham during the night of 15/16 April and that she was not present at any time when Ms Simmons attended at his room.

Ms Wendy Gilroy also works for Bupa as an extended care assistant. At about 8.00am on 16 April she was serving breakfasts to the rooms and noted that Mr Cobham was not in the dining room. She considered this odd because he was *“usually up early and out in the dining room.”* She went to his room to check on him. Ms Gilroy then gives this account:

“When I went in, I found him in the bathroom facing the door with his right arm wedged between the towel rail and wall right up to his shoulder. His arm was blue right up to the shoulder. I was trying to work out where the blood on the floor (sic). The blood had smeared an arch shape on the floor roughly 15 - 20cm long. He had come from (sic) as he had two little cuts on his head and I found a shelf across the room that was attached to the wall and was now lying on the floor and broken.”

“I asked David what had happened and he couldn’t tell me. I asked how long he had been there, but he couldn’t tell me that either. I told David that I was going to get help and ran to get Brooke.”

Ms Gilroy went on to say; *“I noticed David was very cold to touch and I didn’t know how long he had been there. I assume that because he was in his singlet and under pants, I would think he was getting ready for the day. He is usually up and dressed by no later than 6.00am. I’ve never known David not to be up and about by then.”*

Ms Brooke Arnol is a registered nurse working at The Lodge. When she was told of Mr Cobham’s fall she immediately went to his room. She found him *“in the bathroom with his feet tucked underneath him in an awkward position, his right arm was stuck between the rail and the door, a small shelf had been dislodged from the wall,.....”* It appeared to her that Mr Cobham had lent on the shelf which had become detached from the wall causing his right arm to fall between the rail and the wall. She said that Mr Cobham was unable to *“string a sentence together and appeared very confused.”*

Ambulance Tasmania was called and an ambulance arrived at The Lodge at 8.25am. At this time Mr Cobham was still entrapped. The rail was unscrewed enabling Mr Cobham’s release. Paramedics noted at this time that Mr Cobham remained in significant pain. He was given 7.5mg of morphine and then transported to the RHH arriving at 9.18am.

Sometime after Mr Cobham was taken to hospital Ms Kerstan returned to his room to ensure that it had been properly cleaned and tidied following the incident. She then noticed that the motion sensor which had been previously installed was missing. Despite her enquiries she was unable to find out the reason for its removal. She assumed that there had been a *“shortage of equipment”* and it had been taken for another resident’s use.

At the RHH Mr Cobham was unable to move his right arm. However, he did not have any obvious shoulder or rib fractures. Over the following days Mr Cobham developed severe rhabdomyolysis with deteriorating renal function. The decision was taken to implement palliative care only. He died at 5.30am on 23 April 2015.

Post-Mortem Examination

This was carried out by State Forensic Pathologist, Dr Christopher Lawrence. In his opinion the cause of Mr Cobham’s death was aspiration pneumonia following rhabdomyolysis due to entrapment of his right arm in a bathroom hand rail. He explains that in plain English Mr Cobham died of a chest infection following muscle damage due to the prolonged compression of his right arm in a hand rail.

Dr Lawrence has further advised that in his opinion the muscle damage to Mr Cobham's right arm was consistent with it having been entrapped for not less than 1 ½ hours and more probably as long as approximately three hours.

Findings, Comments and Recommendations

The evidence shows that a light plastic shelf was attached to the wall of Mr Cobham's bathroom in a position immediately above a fixed hand rail. Although there is no direct evidence of the incident it is likely that Mr Cobham, either because of a loss of balance or other unknown reason, has placed some weight on the shelf with his right arm causing it to become detached from the wall. In the result his arm has slipped downwards and became entrapped between the wall and the hand rail.

It is the opinion evidence of Dr Lawrence, which I accept, that the muscle damage observed at post-mortem indicated to him that Mr Cobham's arm had been entrapped for not less than 1 ½ hours but more probably for as long as three hours. At what time did the entrapment end? The report of Ambulance Tasmania shows that paramedics attended Mr Cobham at 8.27am and that after an initial examination they directed that his arm be released. The records further show that they secured IV access to his right arm at 9.05am establishing that Mr Cobham's arm had been extricated by this time. This leads me to find that Mr Cobham's right arm was freed by about 9.00am. It follows that Mr Cobham's arm became entrapped 1 ½ to three hours previously, that is sometime between 6.00am and 7.30am. Does the other evidence permit a more precise finding upon the time when the entrapment occurred?

When he was found Mr Cobham was wearing his underwear and not his pyjamas. This suggests that he had risen for the day and had had his shower. The evidence shows that Mr Cobham was in the habit of rising early, a fact confirmed by his Plan of Care and consistent with the evidence of Ms Gilroy who deposes, as I have already noted, that it was his practice to be up and dressed by 6.00am. It is at this point that I need to deal with the apparent inconsistent evidence relating to Ms Simmons. If one accepts the hearsay evidence of Ms Kerstan then it would follow that Mr Cobham could not have had his fall until sometime after 6.45am as it was at this time he was supposedly observed by Ms Simmons to be asleep in bed. However, in her own direct evidence contained in a sworn affidavit Ms Simmons has deposed that she made her last check of residents at between 6.00am and 6.15am and not at 6.45am, although she could not be sure Mr Cobham was one of the residents she checked.

In my view, it is unlikely that Mr Cobham was asleep in his bed at 6.45am. This is so because it is considerably beyond the time it seems that he was habitually up and showered as deposed by Ms Gilroy. Too, if he was still asleep at this time it is problematic that he would have had time to have woken, got up, attended to his toileting including showering and partially dressing before 7.30am, which is the latest time he could have become entrapped, given the evidence of Dr Lawrence. Furthermore, I am not persuaded to accept that Mr Cobham was checked by Ms Simmons at between 6.00am and 6.15am given that she is unsure in her own mind that such check was made.

Despite the evidentiary limitations it is likely in my view, and I so find, that Mr Cobham, consistent with his usual practice, was up and showered by around 6.00am or shortly afterwards. It was soon after this, perhaps around 6.15am, that the incident occurred in the bathroom leading to his right arm becoming entrapped. I further find that following this incident nobody checked Mr Cobham until Ms Gilroy attended his room about 2 hours later.

The facts surrounding Mr Cobham's entrapment give rise to a serious matter of concern. It relates to the failure on Bupa's part to comply with its own Plan of Care prescribed for Mr Cobham

The Plan of Care for Mr Cobham relating to his hygiene includes the following paragraph under the heading, **How to meet my expectations (strategies)**:

*“**Shower/Hygiene** I get up between 0600-0700, I like to shower every day. I need full assistance by x1 staff member. I have a regimented routine. I like to shower dress before breakfast. I can be resistive to staff assistance due to lack of insight into my care requirements. I need to keep to my routine otherwise I can attempt to shower myself or become very confused and agitated. I can be impulsive due to my short-term memory loss.”*

Also relevant to the issue of Mr Cobham's care needs is this comment made by Ms Kerstan in her affidavit:

“.....David liked getting up early in the morning to have a shower without assistance as he believed he was independent enough to do it himself. I believed that he did need assistance and as a result had placed a motion sensor in his room to alert night staff of this so they could be present while he is showering and assist him if necessary.”

It is clear from the above material that Bupa was aware of Mr Cobham's practice of rising early and showering. It is evident too that it was recognised that Mr Cobham required early morning assistance and that he was inclined to proceed unaided if that assistance was not forthcoming. It is clear that because of this predilection Bupa recognised the need to install a motion sensor in Mr Cobham's room to alert staff that he was out of bed and in need of assistance with his morning hygiene.

Notwithstanding the above it is evident that:

- Although Ms Kerstan, as Bupa's Clinical Care Co-Ordinator, recognised Mr Cobham's need for morning assistance this need had not been conveyed to Ms Simmons as indicated by this comment in her affidavit; *“David was our most independent and mobile resident. David required no aids for walking, showered himself and dressed himself all the time.”*
- Although Bupa had considered it necessary to equip Mr Cobham's room with a motion sensor no procedures were in place either to ensure that it remained in situ or that the fact of its removal was conveyed to those persons responsible for his care, most notably at night.

- Bupa had not formulated and put in place a clear strategy to provide Mr Cobham, on a daily basis, with the level of assistance that his state of health required.

The circumstances of Mr Cobham's prolonged entrapment and injury must have caused him significant pain and considerable distress, more so because of his diminished mental state. It is clearly a matter of serious regret that he was not rescued at an earlier time. Had he been it is likely that his rhabdomyolysis with its associated pain would not have evolved leading to his death. It remains for me to observe that this most unfortunate outcome would, in all probability, have been avoided if Bupa had provided the degree of assistance to Mr Cobham which its own Plan of Care identified as being required.

The circumstances surrounding Mr Cobham's entrapment and consequential death lead me to **recommend** that Bupa carry out an audit of all its residents' Plans of Care with a view to ensuring firstly, that those staff responsible for compliance with the requirements of each Plan are aware of its contents and secondly, that strategies are in place to ensure that each Plan is complied with.

I have decided not to hold a public inquest into this death because my investigation has sufficiently disclosed the identity of the deceased, the date, place, cause of death, relevant circumstances concerning how his death occurred, and the particulars needed to register his death under the *Births, Deaths and Marriages Registration Act 1999*. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigation conducted by me.

In concluding, I convey my sincere condolences to Mr Cobham's family and loved ones.

Dated: 19 December 2016 at Hobart in the State of Tasmania.

Rod Chandler
Coroner